

**'DOING BREAST WORK':**  
**Feminism(s), Foucault and the Case of**  
**Cosmetic Surgery**

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## ABSTRACT

This thesis is concerned with the diverse ways in which plastic surgeons, surgical corsetieres and their clients 'do breast work'. Conversations with women clients and cosmetic surgeons suggest that cosmetic surgery is not only about sculpting and changing body shapes; it is also about recrafting identities.

The thesis uses conversations about embodied experience to problematise dominant assumptions about both femininity and cosmetic surgery. I suggest that feminist attention to the hegemonic understandings of femininity often neglect dimensions of cultural production that lie outside the field of textuality and homogenise the experiences of women clients.

I recognise the attention to contradiction and examples of ambiguity and resistance used in this thesis are not necessarily representative of the way cosmetic surgery is used by the majority of women. Rather than generalising from these examples, I use specific cases to problematise theoretical and cultural generalisations about feminine embodiment and its relation to the discourses and practices of cosmetic surgery.

Cosmetic surgery is constructed as a social field and a cultural practice available for sociological analysis. The thesis focuses on cosmetic surgery as simultaneously containing elements of oppression, exploitation, transformation and possibility. Through an examination of the contradictions, ambiguities, silences and resistances surrounding the discursive practices of cosmetic surgery, the thesis seeks to provide a practical example of an embodied feminist/postmodernist sociology of the body.

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Figure 1.1: Breast size, class and identity. Source: Tower Cards, Ivory Tower Publishing Co., Inc. 125 Walnut St, Watertown, MA 02172, USA.

## CHAPTER ONE

# 'COMPULSORY FEMININITY' AND 'FEMINIST EXISTENCE': DECONSTRUCTING THE OPPOSITIONS

*"Would anyone care to learn something about the way in which ideals are manufactured?...Does anyone have the nerve?..."*

*Nietzsche (1956)<sup>1</sup>.*

In the west, the ideal of sexual attractiveness is said to be upheld voluntarily, rather than inflicted by a compulsory operation to change the shape of women's anatomy. But the obsession with one particular shape, everywhere promoted by the media, is no less of a definite statement about expectations for women and their sexuality.

Confronted with the strictness of this cultural ideal, we need to understand the meanings and values attached to this shape. We also need to understand the mechanisms which engage women in a discourse so problematic for us; and we need to know how women actually perceive themselves in relation to this idealised image

Rosalind Coward (1984)<sup>2</sup>.

## 1.1 CONSTRUCTING THE DISCURSIVE FIELD

[This thesis considers how plastic surgeons, surgical corsetieres and their clients employ cosmetic surgery discourses and practices to (re)construct notions of femininity, sexuality, pleasure and desire.] Cosmetic surgery is problematised as an ambiguous and contested site. [Attention is focused on sites of rupture, strategies of resistance, opportunities for empowerment and the ways in which ideals of femininity and masculinity are constructed and/or challenged through cosmetic surgery.] An analysis of cosmetic surgery is situated within a critical discussion of feminist and sociological literature on femininity and female bodies. [Understanding femininity, sexuality, pleasure and desire as socially constructed within discourses which are historically and culturally specific is a major focus of this thesis.]

My research into cosmetic surgery is not meant to be representative of the experiences, discourses and practices of the total population of the cosmetic surgery clients or the plastic surgeons. I recognise that the examples of ambiguity and resistance employed are contingent examples of the way cosmetic surgery is used by many women. Instead of generalising from these examples I focus on specific cases to problematise theoretical and cultural

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<sup>1</sup> Nietzsche (1956): 'The Aesthetic Ideal' in *The Genealogy of Morals*.

<sup>2</sup> Coward, 1984: 40.

generalisations about feminine embodiment and its relation to the discourses and practices of cosmetic surgery.

I suggest that feminist attempts to deconstruct the discursive politics and practices of cosmetic surgery and/or femininity must also recognise that feminism itself is a powerful controlling discourse. The purpose of this thesis is not to provide a 'politically correct' feminist understanding of cosmetic surgery and/or femininity, but to consider cosmetic surgery as simultaneously containing elements of oppression, exploitation, transformation and possibility. Through an examination of the contradictions, ambiguities, silences and resistances surrounding these discursive practices, I wish to provide a practical example of an embodied feminist/postmodern sociology of the body.

Tensions between feminist theories of embodiment and cultural practices that involve cutting into the female body can be illustrated by a comparison of debates among feminists about clitoridectomy and cosmetic surgery. Within most feminist theories of embodiment both clitoridectomy and cosmetic surgery are constructed as 'unnecessary' forms of surgery. Constructing clitoridectomy as 'genital mutilation' or cosmetic surgery as 'self mutilation' (Wolf, 1991: 230) is however not the only way to interpret these cultural practices. Such analyses are counter-productive because they actually serve to limit the way feminists might think about clitoridectomy or cosmetic surgery. Both clitoridectomy and cosmetic surgery bring into focus the way that the body is used and disciplined to secure particular forms of femininity. Rather than dismissing cosmetic surgery as an illegitimate social practice, it seems more important to explore how connections are made between ideals of femininity and the surgical alteration of the female body. Through attending to how social practices inform meaning and constitute female identity across time and space it becomes possible to incorporate embodied experience into theoretical analyses of the historical and cultural contexts in which these practices are located.

When I began this research I assumed that clitoridectomy was a non-Western tradition. Therefore I was surprised to discover that genital surgery is also available in Western industrialised societies as a form of cosmetic surgery. Western medicine offers genital surgery for aesthetic, reconstructive and functional problems<sup>3</sup>, including 'cosmetic surgery to trim the labia minora', and

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<sup>3</sup> In, 'Like a Virgin: Intimate plastic surgery' (*Cosmopolitan*, 05/94, by Kate Graham, pp. 124-128). The article was also advertised on the cover as 'Intimate plastic surgery The women who pay for a

'restore virginity' (*Mode*, October/November, 1993). Recognition of the ambiguity surrounding the social, spatial and discursive boundaries that inform Western understandings of genital surgery adds considerable complexity to the way these issues are taken up and debated within and between cultures. Female sexuality is often understood and experienced differently in cultures where clitoridectomy is routinely practised. Carol Vance suggests that clitoridectomy has been practised for a variety of reasons, for example, to render women aesthetically more feminine, to enhance status and to ensure economic security for daughters through marriage (Vance, 1992: 139). Vance argues that instead of outright condemnation of clitoridectomy<sup>4</sup>, it is more important for Western feminists to consider the frameworks they bring to an understanding and/or critique of this particular cultural practice (Vance, 1992: 139-140). Vance's critique of Western understandings of clitoridectomy can also be applied to most feminist critiques of cosmetic surgery. In Chapter Two<sup>5</sup> I argue that feminists who engage in critical analyses of cosmetic surgery should also reflexively problematise the theoretical frameworks which they bring to this particular social practice.

Comparisons between clitoridectomy and cosmetic surgery illustrate the complexity of the debates and problems of ambiguity associated with feminist critique and intervention. For instance, women might use cosmetic surgery and clitoridectomy in similar ways. The language used in the article entitled 'Securing Her Assets' (*N.Z.W.W.* 08/03/93), about Dolly Parton's marathon eleven hour cosmetic surgery 'for a new body and face', implies that cosmetic surgery can be used to add economic and/or social value to the female body. Like clitoridectomy, breast surgery and cosmetic genital surgery can also be interpreted as ways in which women can become more feminine, enhance or

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tighter vagina', and listed in the contents page as 'Like a Virgin - Intimate Plastic Surgery. Women who have opted for intimate tucks and trims' (p. 7). This article constructs a binary opposition between legitimate plastic and illegitimate cosmetic surgery. It suggests that there are women who 'genuinely need genital surgery', and by implication women who do not - 'Of course, surgery may also be requested for aesthetic reasons'. This opposition is reproduced in discourses associated with breast surgery (see Chapter Three, Section 3.3 under 'Breast Reduction'). Both breast and genital surgery are used for 'functional problems', 'aesthetic reasons', and for 'reconstruction' (following mastectomy or 'disfiguring cervical cancer surgery'). Like breast surgery genital surgery has a social component: 'a "vag job" isn't some freaky Californian fad. It's an option that's taken the suffering out of sex, sport and showering for more than a few satisfied customers' justified through 'inability to wear normal underwear', or 'tight jeans' (pp. 124-128).

<sup>4</sup> For example; in contrast to British Amnesty International demands for criminalisation and economic sanctions against countries that do little to stop clitoridectomy practices, some Non-Western activists argue for a more moderate position on clitoridectomy based on reform through cultural understanding and public education (*Guardian Weekly* 22/07/94, p. 25).

<sup>5</sup> See Section 2.6.

maintain their status and ensure economic security by artificially maintaining a particular identity.

\* In this thesis I pose questions about breast surgery as a social practice. I consider what those who are engaged in cosmetic surgery have to say about it, and I problematise the understandings and assumptions which feminists often bring to a critique of this cultural practice. This research agenda raises several important methodological issues about doing feminist research in this area.

\* Nicola Armstrong suggests research is a journey (1993: 2). I also think of my research into cosmetic surgery as a journey. As I have engaged with the topic my orientation to cosmetic surgery has shifted dramatically, from a simplistic view of cosmetic surgery as violence against women, to one that recognises the contradictions and ambiguities involved in this social practice.

My analysis of breast surgery was directed by a desire to take seriously the agency of women who choose cosmetic surgery. Whereas previous feminist research into cosmetic surgery has focused on articulating women's subordinate position and victimization within medicine (see Morgan, 1991; Wolf, 1991; Bordo, 1993a;), my interest was in exploring the contradictions and ambiguities involved. This ontological position was not only challenging theoretically; it directed the way I constructed each chapter. It also placed constraints on the way I was able to use language in this text. For example, once I started questioning the binary oppositions constituting nature/culture and agency/false consciousness, I had to critically reflect on the way I was opposing analyses of cosmetic surgery as 'discourse' and cosmetic surgery as 'oppression'.

I deliberately chose a research topic that problematised established feminist analyses. As a result my field of inquiry does not sit easily within a conventional feminist research paradigm. The central tenets of 1980s feminist inquiry as research 'by', 'for' and 'on' women (Armstrong, 1993: 10) did not fit easily with my commitment to situate women's experiences of elective breast surgery within a wider network of the relations and practices surrounding cosmetic surgery. This included interviewing plastic surgeons, problematising dominant print media discourses of cosmetic surgery and developing a critical engagement with feminist theories about cosmetic surgery and beauty work.

Three of the touchstones of feminist research - consciousness raising<sup>6</sup>, research for social change/liberation<sup>7</sup> and research based on feminist theories of male domination/female subordination<sup>8</sup> - do not fit easily into research in an area where women voluntarily engage in practices that feminists have previously identified as oppressive and exploitative to women. There is a tension between feminist research methods that attempt to involve participants in the research process and the production of feminist analyses which construct their knowledge and experience as a form of 'false consciousness'. This involves privileging feminist knowledges about the world relative to the subjective and personal knowledges of individual actors, a process which alienates respondents from the research.

In pursuing my research agenda I did not want to make value judgements about women's engagement in the discourses and practices of cosmetic surgery. Rather I wanted to give women a chance to speak about their experiences and have their words taken seriously. I also wanted to problematise the construction of plastic surgeons as 'patriarchal oppressors' of women. For me this involved recognising that plastic surgeons and cosmetic surgeons are not a homogenous group. There are many differences between individual surgeons and sites of contestation on issues relating to professional boundaries, ethics and plastic surgery techniques within the discipline itself.

The research explores the various ways in which female identities are (re)crafted through cosmetic surgery. Drawing on a social constructionist approach to gender I explore femininity as a cultural concept which shapes, and is shaped by, sets of understandings and social processes. This approach to gender raises important questions of subjectivity, agency, experience and process. It asks how various gendered practices are simultaneously reproduced and transformed, including how they are understood by those who engage in them. Social constructionist approaches assume gender to be problematic category. Female embodiment is experienced, constructed and (re)defined through popular representations, social practices, and contemporary discursive meanings of femininity. Cosmetic surgery is analysed, not simply as a medical process which involves the surgical (re)contouring of the female body, but as a set of understandings and practices which connect cosmetic surgery to cultural definitions of the body and the social construction of femininity.

<sup>6</sup> See Cook and Fonow (1991: 3-4).

<sup>7</sup> See Acker et.al. (1991: 136-137).

<sup>8</sup> See Harding (1987: 185).

Discursive texts, such as those associated with feminism and cosmetic surgery, construct and deploy particular ideas about the female breast and femininity. The next section considers a selection of feminist texts and material drawn from magazines and newspapers that make connections between breasts and femininity. This is followed by an analysis of a selection of print media texts which in various ways construct a masculine aesthetic.

## 1.2 (CON)TEXTUALISING COSMETIC SURGERY

This exploration of cosmetic surgery through research into breast surgery engages with an existing feminist literature on breasts, femininity and sexuality. Within this literature breasts are variously described as:

'... the bodily site where notions of femininity intersect' (Lupton, 1994: 74).

'...an icon of femininity' (Finkelstein, 1991: 102).

'...woman's symbol of femininity' (Coney, 1991: 64).

'...a source of female pride and sexual identification but they are also a source of competition, confusion, insecurity and shame' (Cirket, 1992: 11).

'...a symbol of womanhood and of sexual arousal' (Cirket, 1992: 11).

'...the most visible sign of a woman's femininity, and a signal of her sexuality' (Young, 1990b: 191).

In contemporary Western cultures breasts are intimately connected to dominant understandings of adult female identity. The previous extracts describe the female breast as a 'sign', 'symbol', 'signal', and an 'icon' of 'femininity', 'sexuality' and 'womanhood'.<sup>9</sup> Dominant metaphors associated with the female breast indicate that elective surgical alteration of the breast tends to be associated with enhancing femininity and/or sexuality as opposed to approximating to an 'average' appearance<sup>10</sup>. The messages contained in written and spoken texts communicate understandings about breasts and body size which shape the way people respond to cosmetic surgery. According to Lupton:

<sup>9</sup> The cartoons in Figures 1.1 (page V) and 1.2 (page 15 ) illustrate many of the social stereotypes that are constructed around women's breasts.

<sup>10</sup> In comparison, other forms of cosmetic surgery (nose reconstruction, bat ear correction or liposuction) attract none of the connotations about femininity and sexuality attached to elective breast surgery.



...linguistic processes construct and privilege certain definitions and meanings and the processes by which certain interests, norms, values, and opinions receive attention over others (Lupton, 1994: 73).

Discourses communicate ideas about how femininity is constituted and understood. To paraphrase Foucault (1978: 11) what is at issue, briefly, is the overall "discursive fact", the way in which cosmetic surgery is "put into discourse." The mass media are the most common source of information about cosmetic surgery, and therefore have a powerful influence on how cosmetic surgery is commonly understood as a way to rework the body (Fox, 1993: 3; Lupton, 1994: 74). These discourses also construct particular meanings of cosmetic surgery and the processes through which medical definitions of the need for modification and 'rectification' through cosmetic surgery, are privileged. According to one plastic surgeon<sup>11</sup>, cosmetic surgery articles sell newspapers and magazines:

...it (cosmetic surgery) sells papers, it sells magazines... It used to be said that if they had a picture of Diana, Rachel Hunter or an article on cosmetic surgery they sell better. People like reading about them - Diana, Rachel Hunter and cosmetic surgery (Plastic Surgeon 2: 21/04/94).

Print media texts reflect and reproduce dominant understandings of cosmetic surgery as enhancement of femininity. Within this thesis the concept of 'femininity' is problematised. It is approached as a concept implicated in representations and understandings of female history and identity through time and space. Thus notions about femininity and the 'ideal' female body vary throughout history and between cultures, and can be accessed through images, texts and the talk of women who engage in feminine beauty practices. Denise Riley has suggested that feminine identities are historically unstable and contested through discursive formations such as those associated with feminism (1988: 5). Linguistic concepts that speak to the body like 'woman', 'girl', 'feminist' and 'femininity' are political categories because they attach particular meanings and/or identities to the body.

Like femininity, cosmetic surgery is wholly implicated in a politics of identity. Publications aimed at women include articles on cosmetic surgery which often

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<sup>11</sup> This plastic surgeon was interviewed for this study.

assume a homogeneous female viewer or reader<sup>12</sup> - someone who is white, heterosexual and middle-class. The following selection of magazine article titles and newspaper headlines promote cosmetic surgery as a way to achieve feminine 'beauty' or 'perfection':

## COSMETIC SURGERY AS DISCOURSES OF FEMININE BEAUTY

Classic artists create timeless beauty. Plastic Surgery Arts (American Advertisement reprinted in *Cleo*, August 1985)

What Cosmetic Surgery Can Do For You (*The Australian Women's Weekly*, 02/93)

Plastic Surgery: What Price Perfection? (*Mode*, October/November 1993)

Make me beautiful! We road-test three top cosmetic surgeons (*Cosmopolitan*, 07/94)

These print media texts link cosmetic surgery to ideals of femininity. Cosmetic surgery is presented as a way to achieve 'beauty' and 'perfection'. One of the titles implies that purchasing cosmetic surgery is as simple as buying a car, while another suggests cosmetic surgeons are 'classic artists' that create artistic masterpieces out of the bodies of women<sup>13</sup>. The implicit message contained in these texts is that cosmetic surgery can be used to access happiness and rewards previously attainable only by 'beautiful' and 'perfect' women. In comparison, articles in women's magazines which discuss celebrities who have cosmetic surgery tend to use language that implies that their cosmetic surgery decisions are not to be taken seriously:

Busted! Who has and hasn't had a boob job in Hollywood (*Cleo*, 09/93)

Nip and Tuck Stars (*Woman's Day*, 22/02/94)

Star Boo Boo's (*Woman's Day*, 22/03/94)

Shock Demi's Fake Boobs (*Woman's Day*, 18/05/93)

The language used in headlines about cosmetic surgery on celebrities trivialises cosmetic surgery and the stars who use it - 'boobs', 'boob job', 'nip', 'tuck', and 'boo boo'. The message contained in these statements suggests that cosmetic surgery is a frivolous and spurious pastime of the rich and famous. Revealing the cosmetic surgery secrets of the stars exposes the artificiality of their 'image' and implies a privileging of the 'natural' relative to 'perfection' obtained through surgically altering the body. The words efface the pain of cosmetic surgery and the extent to which cosmetic surgery is used

<sup>12</sup> 'Dr. Paula Moynahan's Cosmetic Surgery For Women', discussed further in Chapter Four (Section 4.7) provides a good example of this assumption. Even the chapter on men, titled 'Cosmetic Surgery for the Man in Your Life', assumes a heterosexual female reader.

<sup>13</sup> In the 'Plastic Surgery Arts' advertisement, the text is printed on top of a photograph of a naked woman who is depicted reclining on a chaise longue; the image is reminiscent of the classic 'Venus de Milo' paintings.

competitively by both male and female celebrities to increase their popularity and to access the economic rewards that might follow.

The association between cosmetic surgery and art was a recurring theme within women's magazine articles surveyed over a two year period. In particular, cosmetic surgery articles in up-market magazines like *ES*, *Fashion Quarterly*, and *Elle*<sup>14</sup> as well as articles on liposuction, tended to be accompanied by a picture of a classical painting depicting the fuller figure of the Venus de Milo<sup>15</sup>. The juxtaposition of cosmetic surgery and images of the Venus de Milo implies cosmetic surgery technologies can be used to rework classical beauty. Cosmetic surgery articles were often accompanied by images of scalpels, scissors and/or tape-measures<sup>16</sup>.

In New Zealand plastic surgeons rarely advertise their services outside of the courtesy listings in the 'Yellow Pages'. Instead they tend to contribute to print media editorials on cosmetic surgery. The following newspaper headlines and lead sentences provide a sample of some 'editorial-adverts' for elective breast surgery:

### BREAST SURGERY

Breast reduction 'worth more than the money' (*The Press*, 04/06/91)

Whoever designed breasts did a pretty good job. As manufacturers and suppliers of babyfood they are superb. As sources of sensual pleasure, in sex and in feeding they can be wonderful. They are also an integral part of female body aesthetics...But there are design faults too. One is size variation. When all sizes do the same job, why should some be huge and some barely discernible?... ('Correcting nature's design flaws', *The Press*, 04/07/91)

Reduce to boost lifestyle (*The Christchurch Star* Fashion Supplement 11/93)

Editorial/adverts for cosmetic surgery allow plastic surgeons to present a lot of information about a particular cosmetic surgery procedure. They usually appear in the magazines aimed at women, and in sections of the newspapers likely to be read by women<sup>17</sup>. Most articles present the positive benefits

<sup>14</sup> 'Cutting Edge: Should you? Or Shouldn't You', *ES* (06/93), 'Liposuction: An Empty Promise?', *Fashion Quarterly* NZ (Summer 1993), 'Fat Chance', *Elle* (09/92).

<sup>15</sup> For example in *ES* (06/93) arrows, with price tags attached for each cosmetic surgery operation, identified the parts of the Venus de Milo's body that were in need of correction or improvement.

<sup>16</sup> See: 'The Truth About Cosmetic Surgery', *Readers Digest* (10/92), 'The Enemy Inside', *More* 03/94.

<sup>17</sup> See for example, both 'Correction nature's design flaws' (*The Press*, 04/07/91) and 'Reduce to boost lifestyle' (*The Christchurch Star*, 11/93) editorials feature in the fashion section.

associated with surgically modifying the body, as well as the potential surgical problems which might occur as a result of the operation. They are usually accompanied by one or more former client(s) discussing their experience of the same procedure. An article published in the *Christchurch Press* in 1991<sup>18</sup> was in fact the catalyst for this thesis on cosmetic surgery. The title and the lead sentences in the article simultaneously engaged with notions of the female breast as 'natural' and at the same time seek to disrupt these ideas through information about possible surgical changes to the breast. While some articles suggested that women who engage in cosmetic surgery are narcissistic, unbalanced and vain<sup>19</sup>, most articles presented cosmetic surgery positively as either enhancement of femininity, lifestyle<sup>20</sup> and self esteem<sup>21</sup> and/or restoration of normal appearance. Editorial advertisements on breast reduction are discussed further in Chapter Three<sup>22</sup>.

### 1.3 TOWARDS A MASCULINE AESTHETIC?

Rosalind Coward suggests that women's engagement in cosmetic surgery reflects the lack of alternative subject positions for women. For Coward, women lack choice because women's social worth is assessed in relation to ideals of femininity (1984: 40). Most feminist analyses of cosmetic surgery assume that men are not constrained by an aesthetic masculine ideal and therefore are less likely to be concerned with changing aspects of their physical appearance. Until recently women's bodies were often used to sell commodities while men's bodies were not. However, the noticeable development of an aesthetic masculine ideal within newspapers, magazines and on television suggests that the boundaries constituting relations of looking are becoming ambiguous. The trend towards the objectification of men's bodies began in the advertising and film industries in the 1980s and is increasingly becoming the subject of editorial copy in popular magazines. The following discussion focuses on three recent magazine articles which disrupt some of the assumptions surrounding the relations of looking between women and men.

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<sup>18</sup> 'Correction natures design flaws', *The Press* (04/07/91).

<sup>19</sup> See "I had plastic surgery to look like a Barbie Doll" (*Cleo* 12/93); Implants given to anorexic women (*The Press* 04/05/94); Liposuction: An empty Promise? (*Fashion Quarterly*, Summer 1993).

<sup>20</sup> 'Liposuction brings enhancement of life' (*The Star*, 25/06/91).

<sup>21</sup> "Cosmetic surgery has given me so much confidence and changed my whole world" (*The Christchurch Star* 04/07/92).

<sup>22</sup> See Section 3.3 under 'Breast Reduction'. Chapter Five (Section 5.5) also considers print media accounts of the silicone-gel breast implant controversy and appendix two provides a list of print media articles on cosmetic surgery that came to my attention during the time I was researching the thesis.

A recent article in a popular magazine<sup>23</sup> provided a comparison between the female breast and the male penis. The comment is made, 'men are never pressured to compare the size of their sex organs' (*Listener*: 30/10/93). Within the article the objectification and commodification of women's bodies is contrasted with the relative absence of images which objectify or commodify men's bodies. The article discusses the range of cosmetic surgery procedures for the breast, (to augment, reconstruct, reduce, uplift and enhance), the availability of these procedures and the number of women opting for this form of cosmetic transformation. These statistics are then compared to a lack of cosmetic surgery for the penis, its relative unavailability and the scarcity of men choosing this type of cosmetic surgery procedure. Interviewed in the article Phillida Bunkle poses the following question: What if men's:

...magazines were constantly creating anxiety about the size of men's dicks. But then men, can augment themselves without surgery: Many men deal with anxiety by acquisition. It's a display of power... (*Listener*: 30/10/93).

Cultural ideals about masculinity and men's bodies have come a long way since 'Masters and Johnson refused to release their findings on average penis size, saying it could have a "negative effect" on men' (*Listener*: 30/10/93). Despite the suggestion that men's bodies are not objectified, the objectification of men's bodies is becoming more widespread within popular culture. For example, the 'Australian Men of League' calendar and the New Zealand Rugby Foundation's '1994 Rugged!' calendar, link men's sporting achievement to ideals of masculinity sexuality and desirability<sup>24</sup>. The trend towards the fragmentation of men's bodies is also evident within the modeling world<sup>25</sup>. Certainly women's bodies are more frequently objectified than men's and women are more aware of this objectification, but the increasing objectification of men's bodies and the silence surrounding this emerging social practice does warrant further investigation.

In 1993 *More* magazine (02/93) ran an article on the male body titled 'Men Only'. The article was similar to an article on women's bodies, titled 'Naked Truths' published in late 1992. The title page of the 1993 article on men's bodies had a photograph of a naked male sitting curled up against his own

<sup>23</sup> 'The popular front - What shapes popular images of the female breast?' in the *Listener* (30/10/93).

<sup>24</sup> See Miller, Toby (1990): Especially pp. 78-82 on 'The Gaze' and Miller's discussion of the male pin-up which 'draws out insecurity, instability and contradictions in dominant masculinity. It forces questions like: Why is the male body on conscious display? Which kind of gaze is it expected to consume?' (p. 88).

<sup>25</sup> For example, Elle MacPherson may be 'the body' but male models Marky Mark and Fabio are respectively 'the torso' and 'the chest'.

body, recreating the photographic image on the front cover of Naomi Wolf's *The Beauty Myth*. Front and rear photographs of several naked men (penises blacked out) were shown and the men invited to comment on how they felt about their bodies. Three women were also asked to comment on the photographs. The article is mentioned because it was the first time I had seen a feature in a popular magazine which disrupted the usual discursive order of female objectification, critical subjectification and male gaze<sup>26</sup>. In this article men's bodies, instead of women's bodies, were presented as objects and the men were invited to comment on their bodies in relation to images of an idealised masculinity. Usually an anonymous, implicitly female, narrative encourages women to be self critical about their bodies in relation to idealised images of femininity. Because women were asked to make comparisons between the range of bodies presented in the article, women instead of men provided the objectifying gaze.

In the 1990s we appear to be entering a period in which men's bodies are not only objectified, but also fragmented and critically compared. In *More* magazine's 'Men Only' article men's bodies came under visual and discursive scrutiny, while in 'The Popular Front'<sup>27</sup> their penises are inserted into comparative discourses which link penis size to masculinity, desirability and sexuality. In October 1993 *Cleo* magazine published an article<sup>28</sup> detailing which male celebrities had the largest (and smallest) penises. Standard monthly orders for the magazine sold out in days, and one major retail chain in New Zealand 'had trouble keeping up with the demand'<sup>29</sup>. Assuming it is women who brought these magazines, this suggests that they have the same capacity as men to objectify the other gender. The presentation of an increasingly stylised masculine ideal with popular culture, (tanned, toned, muscled, hairless, slender) means that men have the opportunity to compare their appearance to an aesthetic ideal. In Chapter Four<sup>30</sup> I argue that the way

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<sup>26</sup> 'Breasts - What men really think...': By John Colapinto in *Cleo* January 1994 provides a discursive example of this process which is usually an unspoken aspect of (heterosexual) male/female interaction. In the article men (Colapinto and his male friends) provide the objectifying commentary, and several women talk critically about their breasts (pictured). According to Colapinto: 'In essence, all men are breast men.' He variously describes the female breast; 'as original life-sustainer,...as sign, symbol and prime mover of the male sexual instinct' and constructs 'their identity as real, weighted, bouncing bundles of desire' (p. 104).

<sup>27</sup> *Listener*, 30/10/93

<sup>28</sup> Titled 'More celebrity Penises (this time the big and the not so)'. *Cleo*, October, 1993. Another article published by *Cosmopolitan* in May 1993 titled 'his penis the most intimate guide yet' provides measurements for average size limp and erect. (i.e. provides a standard against which men can judge themselves, much like the way bra sizes provide a standard for women).

<sup>29</sup> Sales Assistant, Magazine Counter (28/10/93).

<sup>30</sup> See Section 4.7.

cosmetic surgery discourses target male bodies problematises assumptions that the discourses and practices of cosmetic surgery subjugate and oppress women exclusively. Although women use cosmetic surgery more frequently than men, there is little difference between the assumptions contained within cosmetic surgery discourses that target men's bodies and those aimed at women. Both employ normalising discourses of masculinity and femininity that are based on culturally constructed ideals of male and female beauty and sexuality.

## 1.4 MAPPING THE THESIS

In the next chapter I reflect on current theories of the body and embodiment. The theoretical emphasis is on how feminists have used Foucault in analyses of gendered embodiment, femininity and cosmetic surgery. The central concepts used in this thesis such as 'discourse', 'normalisation', 'subjugated knowledges', 'disciplinary practices', 'bio-power', 'subjectivity', 'agency' and 'embodiment' are discussed. Feminist critiques of the construction of the female body as deficient or abnormal and in need of correction are identified and problematised. I argue that it is impossible for feminist theories of embodiment to employ discourses of cosmetic surgery as 'unnatural' without constructing a similar constraining discourse of what constitutes the 'natural' body. Finally, I suggest that it is possible for feminists to theorise about cosmetic surgery without constructing women who engage in its discourses and practices as 'cultural dupes'.

In Chapter Three I focus on the experiences of women who have used cosmetic surgery. I reflect on the way in which cosmetic surgery technologies are consumed by women and the relationship between these practices and their view of themselves. I question the way in which textually mediated discourses are used within feminist philosophy to construct theories of the body that reify the experiences of women. I argue that feminist emphases on the operations of hegemony in cosmetic surgery texts neglect some of the important dimensions of cultural production that lie outside the field of textuality. Few feminist analyses of cosmetic surgery reflect on how 'femininity' is practised, experienced and reworked in everyday life. The interviews I have conducted with women clients suggests that women use cosmetic surgery for a variety of reasons: to change the shape of their bodies, to widen or maintain lifestyle options and to recraft aspects of their private and public selves. The binary opposition constituting 'nature' and 'artifice' is problematised, and the historical example of corsetry and tight-lacing is employed to question the notion that the

use of technologies to sculpt, change and discipline the female body is a phenomenon specific to late capitalism.

Chapter Four is concerned with the diverse ways in which plastic surgeons and surgical corsetieres do breast work. I argue that it is problematic to critique the discourses and practices of the medical profession without addressing the needs of particular women for whom cosmetic surgery technologies may be vital or beneficial. I explore the construction and institutionalisation of ideals of femininity through the words and practices of the plastic surgeons and the surgical corsetieres I interviewed. Notions of an alternative 'natural' body within feminist critiques of cosmetic surgery are problematised as cultural constructs. The political economy and the 'political anatomy' of cosmetic surgery are explored.

This chapter explores the way in which differences between plastic and cosmetic surgery are discursively constructed rather than a product of intrinsic differences in surgical techniques or the situations in which they are deployed. The plastic surgeons are located as the 'identity brokers' in the cosmetic surgery field and plastic surgeons careers are made through the organisation and manipulation of the culture of the body. The institutionalisation of plastic and cosmetic surgery as a legitimate medical discipline occurred alongside its emergence as a consumable commodity within popular culture. I consider the role of the plastic surgeons in extending popular understandings of, and exposure to, cosmetic surgery knowledges through teaching, advertising and editorializing of cosmetic surgery practices. This chapter also introduces some questions and observations on the development of an increasingly aesthetic masculine ideal within popular culture.

Chapter Five focuses on the controversy about silicone-gel implants in order to consider what happens when there is a general perception that a particular cosmetic surgery technology does not work. I try to avoid developing a homogenised prescriptive position on cosmetic surgery while retaining a critical engagement with the medicalising discourses which serve the interests of both the silicone-gel breast implant manufacturers and the plastic surgeons who insert them. I suggest that the silicone-gel implant controversy brought cosmetic surgery to the attention of the state. The practices surrounding the development of a register for implants containing silicone-gel are analysed as an example of the way that state policies can be used to discipline the female body and to sanction medical interventions in the population. I discuss how



medical/bureaucratic solutions to the problem of 'unsafe' breast implants may also restore some sense of legitimacy to this controversial cosmetic surgery procedure. Finally the Foucauldian notion of 'subjugated knowledges' is explored in relation to the experiences of women who have had problems with their implants.

The thesis concludes with some reflections on what gets done through cosmetic surgery.

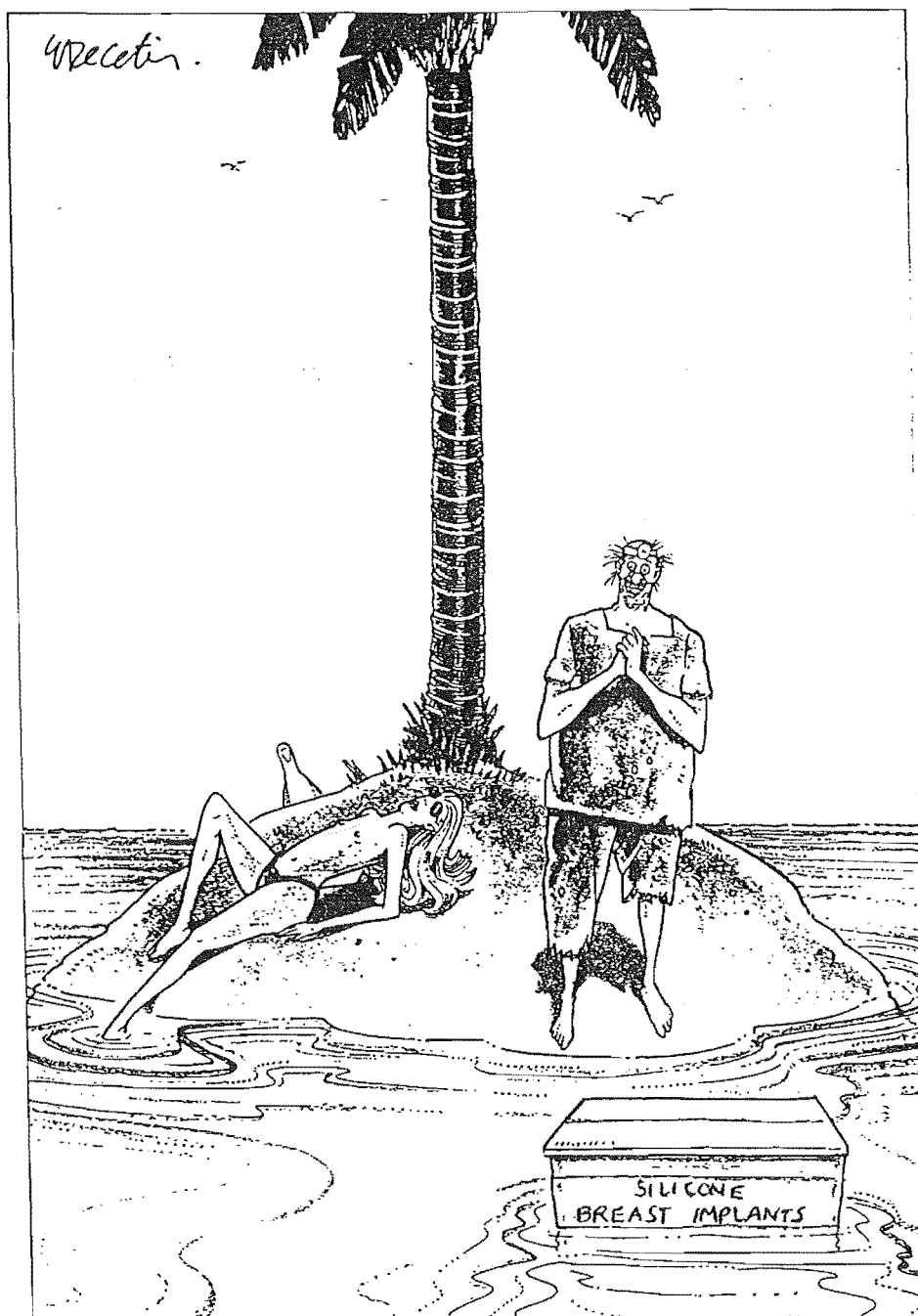


Figure 1.2: Happiness is...? (Source: *Penthouse*, June 1993).

## CHAPTER TWO

### THEORETICAL ORIENTATIONS: (CON)TEXTS, EMBODIMENT AND SOCIAL PRACTICES

"...theory does not express, translate, or serve to apply practice: it *is* practice."

- Michel Foucault (1975)<sup>1</sup>

#### 2.1 THEORETICAL ORIENTATIONS

This chapter of the thesis introduces certain aspects of Foucauldian theory, and discusses its utility in providing a framework for analysing cosmetic surgery. Foucault addressed the way forms of knowledge/power become institutionalised and legitimated through discourses and practices which inscribe on the body a certain way of being. The focus is on Foucault's discussion of how power/knowledge is implicated in the formation and attachment of certain identities to particular bodies<sup>2</sup>. Foucault's analysis is used to explore how certain discursive practices produce, construct and mobilise particular 'norms' of femininity which inscribe the female body.

This research into cosmetic surgery and the beauty industry is set in the context of reflections on my approach to this topic, debates within feminist theory and current analyses of femininity as discourse. This is followed by an analysis of the theoretical aspects of the research problem, and introduces some of the potential contributions of discourse analysis for feminist theory. Existing sociological theories of popular culture are also discussed, including feminist analyses of 'oppression' and 'discourse'. The chapter concludes with a critical discussion of some feminist texts on cosmetic surgery.

In Chapter One<sup>3</sup> I suggested that notions of femininity, sexuality, identity, pleasure and desire are intimately connected. Within Western feminism, femininity is variously constructed, not only in relation to hegemonic 'norms' of heterosexuality and patriarchy (*the ideological or oppression model*), but also through discursive practices and representational culture (*the discourse or*

<sup>1</sup> Michel Foucault: *Politics, Philosophy, Culture. Interviews and Other Writings 1977-1984*. See Lawrence D. Kritzman (Ed). Routledge, New York and London, 1988: xix (italics my emphasis).

<sup>2</sup> See Foucault, Michel (1978): *History of Sexuality, Volume 1* and Foucault, Michel (1980) *Power Knowledge, Selected Interviews and Other Writings*. See

<sup>3</sup> See Section 1.2

*social constructionist model*). In conceptualising 'femininity' Toril Moi differentiates between:

... 'feminism' as a political position, 'femaleness' as a matter of biology and 'femininity' as a set of culturally defined characteristics (Moi, 1989: 117).

For Moi 'femininity' is created in and through culture rather than being innate. According to the social constructionist perspective the understandings which people bring to the images, discourses and practices of femininity are constantly contested and (re)negotiated through subjectivity and culture:

...popular culture is a site of struggle where meanings are contested, and dominant ideologies can be disturbed... (Gamman & Marshment, 1988: 1).

*disrupted.*

In contrast to claims by proponents of the discourse model that the oppression model is now 'unacceptable' (Davis, 1991:26), I consider that the discourse model has not replaced the oppression model; rather 'traditional' feminist theories have been added to, enriched and challenged by these new ways of thinking. It is important for feminists positioned on both sides of the oppression and discourse debate to recognise the utility of both in the investigation of social practices, including those associated with cosmetic surgery. A simple example of the way this opposition between cosmetic surgery as 'discourse' and cosmetic surgery as 'oppression' may be deconstructed can be found in an analysis of two specific types of cosmetic surgery discourses and practices, which have respectively positive/enabling and negative/constraining consequences. Within medical discourse, cosmetic surgery is positively associated with the lifestyle benefits of physical and psychological well-being. However, within critical feminist discourse, cosmetic surgery is viewed as an oppressive practice, negatively associated with social pressure on women to conform to a particular ideal of feminine beauty and associated with risks rather than benefits. In Chapter Four<sup>4</sup> I consider the similarities and differences in the way language is deployed within reconstructive plastic surgery discourses and cosmetic surgery discourses. I suggest that this approach has the potential to account for how discourses can be considered both negative and positive, constraining or enabling, within different social contexts.

This thesis provides a pragmatic analysis of how popular culture and feminine aesthetics influence women's lives. It takes seriously a range of conceptual and

<sup>4</sup> See Section 4.3.

political issues relating to cosmetic surgery, not only because they have an impact on many women, but also because they provide a challenging case for feminist analysis and debate. According to Angela McRobbie (1993):

Femininity is no longer the 'other' of feminism, instead it incorporates many of those 'structures of feeling' which emerged from the political discourse of feminism in the 1970s. But it also, and perhaps most powerfully, exists as the product of a highly charged consumer culture which in turn provides subject positions for girls (and women) and personal identities for them through consumption (McRobbie 1993: 423).

My approach to cosmetic surgery is to see it as a social practice within which personal identities and potential life chances are (re)crafted through consumer culture. Surgeons and clients appropriate liberal discourses of 'choice' and 'rights' to defend and/or promote access to these technologies. For instance, individual women may discuss their cosmetic surgery experiences in terms of 'controlling their own bodies', 'liberation', 'choice' and 'empowerment' - using feminist language to defend practices which feminists have identified as oppressive. Cosmetic surgery discourses contest feminist knowledges and meanings because they occupy similar discursive spaces. Rather than existing outside of feminism, these discourses and practices offer a challenging case for feminist analysis and debate.

## 2.2 DEFINING DISCOURSE

Because there are multiple meanings attached to the concept of 'discourse', I shall present those definitions that relate closely to my own understanding of the term. One way of conceptualising discourse is based on Joan Scott's (1988) definition of discourse as 'not (only) a language or a text but an historically, socially, and institutionally specific structure of statements, terms, categories and beliefs' (Scott, 1988: 35). Discourses are ideologies in use. They are organised and made meaningful through social and institutional practices and also through history, language and written and visual texts.

Cosmetic surgery is a discursive field that provides subject positions for individuals. The discourses surrounding cosmetic surgery are located within social and institutional structures, power relations and processes that construct and contest the knowledges and meanings attached to cosmetic surgery. Within this analysis discourses of femininity are embedded in the social relations of gender; they are used to organise socially-given forms of subjectivity and experience (Smith, 1990: 160). Discourses constitute and are constituted in the

meanings individuals attach to the social world; according to Stephen Ball, 'the concept of discourse emphasizes the social processes that produce meaning' (Ball, 1990: 3). Nicola Gavey (1990) has defined discourse as:

...an inter-related 'system of statements which cohere around common meanings and values...[that] are a product of social factors, of powers and practices, rather than an individual's set of ideas'... (Gavey, 1990: 267).

The goal of discourse analysis is to identify the historically, socially and culturally specific understandings of active subjects. Discourse analysis is a process which involves examining patterns of meaning, and their contradictions and inconsistencies. It involves exploring the way people use language to constitute their own and others understandings of personal and cultural phenomena (Gavey, 1990: 267). Using discourse analysis I unpack multiple narratives about cosmetic surgery. These narratives are theoretical (feminist, postmodern, sociological), representational, textual, medical and personal. Multiple narratives of cosmetic surgery provide evidence of a world of alternative values and practices, the existence of which problematises feminist constructions of the social world.

A central tenet of postmodern theory is its conceptualisation of language as a meaning-constituting system, tied to subjective notions, understandings and practices of culture. Within this analysis, language constitutes the ideas, understandings and meanings surrounding cosmetic surgery; discourses organise cosmetic surgery practices and the processes through which femininity is defined and experienced. According to Jane Flax, within postmodern theory 'language and discursive rules both reflect and are located within complex contexts of social relations and power' (Flax, 1990: 222). Language does not simply reflect social reality, but provides a crucial point of entry for understanding how social relations are conceived, organised, institutionalised and experienced. The discourses and practices of cosmetic surgery construct and deploy particular ideals of femininity that are legitimated within the institution of medicine. It is through these relations and the process by which meanings and categories are constituted within language, that collective and individual identities are historically established and contemporarily perpetuated.

Paula Treichler (1990) also argues that language is not a neutral or objective reflection of the world. She suggests language inscribes meaning through discourse. Within this analysis, language does not simply describe social

reality; it constructs understandings about the subject positions available to actors (doctor/patient) and the meanings we attach to particular social practices (like cosmetic surgery). For Treichler, discourse itself is the site where social practices are made intelligible (Treichler, 1990: 132). According to Treichler, meanings are contested sites: they incorporate a multiplicity of ideas, understandings and significations. Meanings are dependent upon the way they are communicated, interpreted and experienced. Unlike meanings which are constantly (re)negotiated through subjectivity, definitions set limits and determine boundaries. They claim to state what is. Definitions create a hierarchy of knowledge among existing meanings; they distinguish between what is real and imagined, legitimate and illegitimate. According to Treichler, definitions are formulated through a set of complex cultural processes, whereby particular meanings become official and enter discourse in the form of a constructed definition (Treichler, 1990: 124). Treichler grounds her discussion in meanings and definitions surrounding childbirth, but her analysis can also be applied to an exploration of the meanings and definitions associated with cosmetic surgery.

Throughout the thesis I draw on Treichler's distinction between meanings and definitions to suggest a more complex theoretical understanding of how medical definitions of women's subjective realities come to be constructed, codified, institutionalised and mobilized through the discourses and practices of the plastic surgeons and their clients. The subjective/cultural meanings and medical definitions of cosmetic surgery are problematised in relation to oppositional dualisms which construct these knowledges and practices as either legitimate and dominant or illegitimate and subordinate within medicine and feminism. Within this analysis all knowledges are problematic and all meanings are potentially contested through 'subjectivity', 'history', 'language' and 'texts'.

## 2.3 PROBLEMATISING FEMININITY AS DISCOURSE

If discourses construct the nature of the body, rather than reflecting physiological realities, then we should expect to find changing conceptions of what it means to be female and different forms of the idealised 'female' body. Chris Weedon (1987) has suggested that ideals of femininity change over time:

In breaking with notions of 'essential femininity' as natural and/or universal it becomes subject to history and change... (Weedon, 1987: 12).

'Femininity' is not a uniform term describing a particular form of embodiment whose true meaning and real nature are universal and potentially accessible to everyone. There is considerable variation in what 'femininity' means, to whom, and under what circumstances a given meaning, or ideal, may come to constitute an official definition of 'feminine' reality. In Chapter Three<sup>5</sup> I explore the Victorian use of corsetry and the practice of tight-lacing as an example of how techniques to shape the body and ideals of femininity are subject to history and change.

According to Roy Boyne, access to the past is policed through methods of historical inquiry that construct notions about historical truth (1990: 5). Suggestions that contemporary meanings of femininity are more fluid than their historical precedents (Behar, 1991: 282) or that subject positions for women have become 'unfixed' from traditional meta-narratives of femininity (McRobbie, 1993: 408) construct a binary opposition between definitions of femininity as 'tradition' and modern notions of femininity as 'innovation'. The nineteenth century example of corsetry and tight-lacing challenges assumptions that historical definitions of femininity were rigid and fixed. Corsetry and tight-lacing was a contradictory and ambiguous practice that scandalised nineteenth century notions of femininity through constituting new forms of female agency and 'subjectivity'.

Subjectivity refers to a range of social processes that mediate individual experiences and knowledges of the world and thereby contribute to the construction of a person's sense of self. Susan Himmelweit and Helen Cowley define 'subjectivity' as:

...that combination of conscious and unconscious thoughts and emotions that make up our sense of ourselves, our relation to the world and our ability to act in that world...The concept of subjectivity can capture both the notion of people as intentional subjects - actors in the world - and at the same time as subject to forces beyond their conscious control (Himmelweit & Cowley 1992: 7).

Subjectivity refers to identity; both are acquired in a social context. According to Himmelweit and Cowley, an analysis of how subjectivity is produced through language and differences between individuals can provide insights into why people behave differently and in ways that are not always intended or in their own interests (1992: 7). The social contexts in which modern forms of

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<sup>5</sup> See Section 3.1.

femininity are defined, and feminine identities acquired, include forms of representation within popular culture and 'textually mediated'<sup>6</sup> discourses and practices, such as those surrounding cosmetic surgery. [Within this analysis bodies can be read as texts; they reflect individual forms of subjectivity and the social contexts in which definitions of the body are constituted.] According to Joan Scott, subjectivity is experienced and described from 'fundamentally different - often irreconcilable - perspectives, each contradictory and equally meaningful' (1992: 24).

The expansion of discourses of femininity has been associated with the 'science of femininity'<sup>7</sup> epitomised in the beauty and cosmetic surgery industries. Femininity discourses are in a constant state of (re)definition, expansion and change. This constant redefinition of femininity means that, at any one moment, there is not one discourse of femininity, but several simultaneous changing sets of understandings about what is most characteristically female. Importantly, the medical, technological and aesthetic discourses which inform cosmetic surgery as a social practice, are intimately linked to pervasive socio-cultural understandings of femininity. However, discourses of 'femininity' are also shaped by their association with 'other' discourses which define what is sensual, pleasurable and desirable for women within Western society, including resistant feminist discourses about women and femininity. Thus each understanding of femininity is derived from a complex intersection of oppositions, texts, images and discursive practices. Significantly, because discourses contain networks of meaning, a critical sociological analysis of the way discourses are deployed, operated and commonly understood at the societal, institutional and individual levels - in terms of agency and subjectivity - becomes vitally important.

Dorothy Smith (1990) seeks to explore the connections between these different levels through analysis of femininity as discourse. She conceptualises femininity:

... as the actual social relations of discourse mediated by texts in which women are active as subjects and agents (Smith, 1990: 161).

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<sup>6</sup> Smith, 1990: 161

<sup>7</sup> By the 'science of femininity' I refer specifically to the creation of new ideals of femininity through advancements in cosmetic surgery technologies. But I also have in mind the production of discourses, images and representations of femininity, within for example, the beauty and advertising industries which use various technological and scientific claims to establish product legitimacy. These scientific discourses of femininity are aimed at the controlled intensification of desire as opposed to the increase of pleasure, and can be compared to Foucault's (1978) discussion of *scientia sexualis* (science of sexuality) in *H.O.S. vol. 1* pp. 53-73 especially p. 63.



For Smith, discourse is an 'ongoing intertextual process' (1990: 161) Smith defines textually mediated discourses as 'the relations organising the dialectic between the active and creative subject and the market' (Ibid). Texts mediate understandings of the contradictory social forces that constitute the relationship between the active consumer and understandings of cosmetic surgery as a medical practice and a market commodity. She suggests, 'textually mediated discourses' exist as socially organised communicative and interpretive practices intersecting with and structuring people's subjective worlds and thereby contributing to the organisation of economic, social, cultural and political processes (Smith, 1990: 162-163). According to Smith, 'texts of, or about femininity... give us access to the social organisation of these relations' (1990: 166). Femininity, pleasure and desire can be explored in relation to the textual discourses vested in women's magazines, television, and advertisements, as well as in the talk women do, the subjective experiences women have, and the images women reproduce or desire in relation to these texts (Smith, 1990: 163).

Drawing on these ideas about 'femininity as discourse', my analysis of cosmetic surgery explores the complex origins and linkages between ideals and representations of femininity, pleasure and desire within the popular press and media, and the way these images are simultaneously influenced by, and used within, the discursive practices of the cosmetic surgery and beauty industries. My analysis of cosmetic surgery explores how individual women relate their subjective experiences as 'active and embodied subjects' to these discourses of femininity within popular culture and the marketing strategies of the cosmetic surgery and beauty industries.

## 2.4 DISCIPLINING THE BODY; FOUCAULT AND NORMALISATION

According to Foucault, discourses contain assumptions about which knowledges and practices are normative or universal. These truth claims are legitimated in technologies of power, which set up a hierarchical opposition between what is common/uncommon, and by implication, normal/abnormal, for example, within research, quantitative and qualitative research methodologies, statistical analyses and within medicine, the medical examination (1978: 145). However, within the discursive construction and legitimation of cosmetic

surgery this process is often reversed<sup>8</sup>. In the process of defining healthy female bodies as 'pathological' and in need of correction, cosmetic surgeons turn the ordinary into the deficient, utilising normatively constructed standards of beauty and/or femininity. These definitions are legitimated through particular practices (like the measurement of the location of nipples in the ideal breast) and by implication may change through time, space and locale. According to Ball, within medicine:

...the processes of examining, embodies and relates power and knowledge in technological form... [T]he examination... is the objectification of the subject by processes of classification and division (Ball, 1990: 3).

The construction of the feminine body in relation to particular normative ideals and/or 'deficiencies' implicates technical forms of knowledge/power that are acquired through the medical examination. Within this analysis the body sits on the cusp of intersecting (medical) discourses which define it as healthy in some contexts and as pathological and in need of correction in others. The plastic surgeons use historically (and culturally) specific definitions of femininity to articulate the criteria for the 'healthy' female body. The cosmetic surgery industry (re)creates a normative ideal of aesthetic beauty and/or body size, it defines perfection and classifies 'other' body shapes as unworthy according to this standard. The way in which individual plastic surgeons use the medical examination to (re)create and deploy normative ideals of beauty and body shape is explored in Chapter Four<sup>9</sup>. There it is suggested that the idiosyncratic judgements of the plastic surgeons - in relation to nipple placement, breast size and body shape - are disguised and legitimated through the institutionalisation of medical discourses and practices which appeal to 'objectivity', and 'scientific authority'.

Foucault suggested that the classification and objectification of the body within medicine is an historical process arising out of techniques of population control that were originally developed and refined through the state. For Foucault technologies of surveillance and examination are constructed through an essentially normalising legislative activity and legitimated within the institutions of the state (Foucault, 1973: 35-36; 1978: 140-144). He uses the notion of 'governmentality' to develop an historical analysis of how discourses and practices come to be constructed, codified and mobilised within and

<sup>8</sup> Kathryn Pauly Morgan (1991) terms this course of action 'the pathological inversion of the normal'. Defined as a process through which the 'naturally given' and 'ordinary' increasingly come to be perceived as the 'ugly' and the 'technologically primitive' (p. 41).

<sup>9</sup> See Section 4.4.

through these institutions (Foucault, 1979: 20). In the remainder of this section and in the following section I unpack some of the central tenets of Foucault's theories and consider the way in which they have been appropriated by feminists to explore gendered embodiment.

According to Lois McNay (1991), one of the most important contributions that Foucault's theory of the body has made to feminist thought is to provide a way of conceiving of the body as a concrete phenomenon without subordinating its materiality to a fixed biological or pre-discursive essence (McNay, 1991: 128; 1992: 17). The Foucauldian model suggests it is impossible to know the materiality of the body outside of its cultural significations (McNay, 1991: 128-131; 1992: 38). Of particular interest to feminism has been Foucault's insistence that the body is an historically and culturally specific entity.

This thesis incorporates a Foucauldian/post-structuralist analysis of the body as an historical achievement, discursively constructed within culture and governed through institutionally sanctioned techniques and tactics of surveillance and control. It also utilises Sawicki's appropriation of the Foucauldian notion of 'governmentality' which refers to a form of disciplinary power that operates through sets of disciplinary practices which have as their primary objective the government of the body. Sawicki suggests that Foucauldian analysis places the development of these disciplinary practices alongside the historical development of institutionalised definitions of the body (Sawicki, 1991: 67). Postmodern social thought rejects the notion of a universal human history, characterised either by the progressive development of the philosophical ideas of reason, justice, truth and freedom or inevitable changes in the relations of production. Consistent with this, Foucault suggested history is characterised by a set of random dominations, whose object is the control of territories and populations. Foucault placed the human body at the centre of this struggle between different power formations, or systems of domination, the history of which has shaped and reshaped the body according to the different warring forces or systems of domination acting upon it (McNay, 1991: 127).

According to Foucault, the body is produced through power, it is constructed through tactics and techniques of surveillance and control which were facilitated by and developed out of the institutional practices of governmentality. Foucault termed these tactics and techniques 'disciplinary practices'. These are located within the institutions of the state, for example,

the army, the school, the hospital and the prison and also at the micro level of society in the everyday activities of individuals (Foucault, 1978: 139-148; Bartky, 1988: 62; Sawicki, 1991: 67). According to Sawicki these practices regulate individual behaviour by:

...creating desires, establishing norms against which individuals and their behaviors and bodies are judged and against which they police themselves (Sawicki, 1991: 68).

Within this analysis cosmetic surgery can be seen as a 'normalising' technology that both produces and responds to desires for a particular aesthetic ideal or body shape. Foucauldian analysis suggests cosmetic surgery technologies subject the body to scientific investigation and normalisation based on ideals that are derived from the wider population. The subject is constructed through forms of power which subjugate the body by turning it into an object of knowledge. One of the processes of subjugation involves the objectification and normalisation of the body within medicine (Grace, 1989: 245; Sawicki, 1991: 84). Foucault referred to the regulatory power associated with these technologies of surveillance as the 'bio-politics of the population' (1978: 139).

For Foucault, power over life was organised around the disciplines of the body and the regulation of the population (1978: 139). Through the development of techniques of surveillance and intervention, bio-power sought to achieve the subjugation of bodies and the control of populations. The gradual incorporation of the mechanisms of bio-power into techniques of government meant that social and demographic problems (for example, the birthrate, mortality, the level of health, life expectancy, longevity, public health, housing, migration, education, crime, unemployment and so on) became concerns for state intervention and control:

...'bio-power...brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of transformation of human life' (Foucault, 1978: 143).

Within this analysis, cosmetic surgery can be seen as a discipline of the body and a form of 'knowledge-power', based on the explicit calculation of idealised body shapes (for example breast sizes) developed through medical techniques of surveillance and examination, and its technologies interpreted as 'mechanisms' for the transformation and sculpting of bodies and identities. In Chapter Five<sup>10</sup> the notion of 'bio-politics' is explored in a discussion of recent

<sup>10</sup> See Sections 5.7 to 5.10.

responses by the New Zealand government to medical disputes involving women's bodies. While Foucault's analysis focused on the way in which state institutions construct and govern the body, the major focus of this thesis explores governmentality in relation to the micro-practices of individuals (plastic surgeons, surgical corsetieres and cosmetic surgery clients). I explore the inherent contradictions and ambiguities in the way the bodies are constructed, disciplined, sculpted and transformed through cultural texts, agency, subjectivity and the discourses and practices cosmetic surgery.

It is against this background that the body comes to be seen as a social object and a political issue. The development of disciplines of the body, in medicine and psychology for example, gave rise to numerous modes of surveillance, examination, intervention and control. At the same time the body provided a mark of individuality and a site of struggle over meaning. In the case of health, power spoke of and to the body, it became an object and target of knowledge, signification, normalisation, discipline and regulation (Foucault, 1978: 145-148). Within Foucauldian analysis, the body represents an ambiguous and contested site where the normalising mechanisms of bio-power and individual strategies of conformity and resistance intersect and are played out. The notion of 'bio-power' is particularly relevant to an examination of cosmetic surgery as a site of normalisation and individual agency.

Surgical modification of the breast has important implications for how individual women feel about themselves and their bodies. Cosmetic surgery is not only about sculpting and changing body shapes, but is about recrafting identities. Connections between cosmetic surgery, modification to concepts of self and understandings about the way you are viewed by 'others' are particularly apparent in the way individual women talk about their breast surgery<sup>11</sup>. In the following section I consider the way feminist theorists have analysed the body and suggest how this might be applied to an analysis of cosmetic surgery.

## 2.5 DISCIPLINING FEMININITY; FEMINISM(S) AND NORMALISATION

According to Sandra Bartky (1988), Foucault did not explore the gendered features of the historical development of tactics and techniques of surveillance

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<sup>11</sup> See Chapter Three, Section 3.3 under 'Breast Augmentation'.

and control of men's bodies and women's bodies. [For Bartky women's bodies have been made more docile than men's through disciplinary practices which produce a form of embodiment that is peculiarly feminine (1988: 64).]

Bartky considers three categories of disciplinary practices which have been aimed specifically at the development of feminine bodies. First, she documents techniques of surveillance and control that have been traditionally aimed at encouraging women to produce a body of a certain size and general configuration, for example techniques of dieting, exercise and cosmetic surgery (1988: 65-66). Second, Bartky explains how women's physical movement through social space is different from that of men. She attributes this difference to a set of disciplinary practices that produce in the female body a specific repertoire of recognisably feminine gestures, postures and movements<sup>12</sup>. Finally Bartky considers those practices that are directed towards the display of the female body as an ornamented surface, for example techniques involved in the care of the body, makeup, cosmetics, hair styling and hair removal (1988: 68-69).

According to Bartky, Foucault tended to identify the imposition of discipline upon the body with the operation of specific institutional structures. However, this analysis tends to overlook the extent to which discipline can be institutionally 'unbound' as well as institutionally bound. Unlike Foucault's notion of disciplinary power, which is often tied to total institutions, Bartky argues the discipline of the feminine body is difficult to locate because it is institutionally unbound. The absence of a formal institutional structure, creates the impression that the production of femininity is either entirely voluntary or natural (Bartky, 1988: 75). For Bartky 'the disciplinary power that inscribes femininity in the female body is everywhere and it is nowhere; the disciplinarian is everyone and yet no one in particular' (1988: 74). It is a disciplinary power that is particularly modern.

Lois McNay contends that Foucault, in theory at least, argued that disciplinary regimes always generate their own forms of resistance. In practice, however, Foucault's historical studies give the impression that the body is passive and presents no material resistance to the operations of power (McNay, 1991: 134). Much of Foucault's historical analysis has examined how power relations are installed in bounded institutions; he showed how surveillance has been applied

<sup>12</sup> For example see Iris Young' (1990a) paper 'Throwing like a Girl', in *Throwing Like a Girl and Other Essays in Feminist Philosophy and Social Theory*.

repressively to produce 'docile bodies', but he tended to overlook the forms of resistance or to document its effects.

Nevertheless Foucault rejected the repressive hypothesis of power which sees power as a centralised structure, working exclusively within and through these institutions. For Foucault, power is a diffuse, heterogeneous and productive phenomenon, everyone is implicated in the operations of power, and no one exists outside of its influence. Foucault's counter-discourse of power suggests that no one institution or person has an indefinite monopoly on power and everyone has some degree of access to power and its operation. For Foucault, discourses are important not only for what they say, but also for what they leave out. It is in this space between what is said and what is concealed that it is possible for particular subordinate knowledges and practices to challenge and disrupt the existing discursive (and social) order<sup>13</sup> (Foucault, 1978: 101, 1980: 82).

While I agree with some aspects of Bartky and McNay's analysis of an 'institutionally unbound disciplinary regime of femininity', I do not agree with their implicit analyses of power as repressive, inscribing itself on the docile bodies of women; rather Foucault's notion of the creative capacity of power suggests that over time power can be used by individuals and groups to produce social change and/or new subject positions for actors. Within this analysis the positive and negative effects of cosmetic surgery can be explored: as a form of empowerment that allows individuals to craft new subject positions for themselves and as a medical technology that defines subject positions for actors through notions about what constitutes appropriate ways to rework the body.

Foucault's *History of Sexuality* developed the idea of subjugated knowledges as an explicit example of how experience can be understood as a form of resistance. Like Foucault, I think there is always a potential for resistance to discourse. For example, discourses about beauty and cosmetic surgery target whole female populations as a potential market. In this sense they are potentially repressive. However, just because discourses on cosmetic surgery, or beauty, or femininity target whole female populations, does not mean that women are going to adhere to them passively at all times. In the crafting of bodies from positions and discourses, social actors are able to 'do otherwise',

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<sup>13</sup> Social movements (feminism, environmentalism, gay rights etc.) provide good examples of these processes. See Chapter Five Section 5.11 for a more extensive discussion of subjugated knowledges and reverse discourses.

particularly when the normative discourses on cosmetic surgery and beauty have produced a set of resistant discourses and potential subject positions. However, potential choices and forms of resistance are also limited by certain structural constraints. Chapter Five<sup>14</sup> explores these issues, problematising choice and consent in relation to the structural constraints and unintended consequences of social action. Resistance appears in many forms; dominant discourses are always being disrupted and reinvented challenging a repressive hypothesis of power. Such a notion of resistance is the basis of Foucault's methodological challenge to an abstract social theory based on normative knowledge claims. This central idea is developed in relation to questions of authenticity, con(text), social practices and agency in the remainder of this chapter and in Chapter Three<sup>15</sup>.

## 2.6 BEAUTY AS OPPRESSION OR CULTURAL DISCOURSE?

According to Kathy Davis (1991) feminist analyses of the beauty industry can be divided into two main types of explanation. The first considers beauty as a form of oppression, while the second, consistent with the avant-garde philosophy of postmodernism, considers beauty as cultural discourse (Davis, 1991: 26-27). Traditional feminist analyses of the discourses and practices surrounding cosmetic surgery tend to explain it in terms of economic exploitation and patriarchal oppression. Naomi Wolf, for example, tends to present the women who undergo cosmetic surgery procedures as cultural dupes and the unwitting victims of normalising discourses about beauty and femininity that are imposed upon them (Wolf, 1991: 234)<sup>16</sup>. According to Kathy Davis traditional feminist analyses examine female beauty as a form of repression within which:

...femininity is defined in terms of women's shared experiences, of which the most central is oppression. Power is primarily a matter of male domination and female subordination...the oppression model sees all women as more or less equally oppressed by beauty norms. Feminist interventions in the field of beauty tend to be aimed at freeing women from the oppressive constraints of cultural beauty norms through consciousness-raising (Davis, 1991: 26).

<sup>14</sup> See Section 5.9.

<sup>15</sup> See Section 3.4 in particular.

<sup>16</sup> See her chapter on 'Violence' which is framed entirely within this analysis (Wolf, 1991: 218-269). For another example of this perspective, see Dull & West (1991) which is discussed in Chapter Four Section 4.4.



What Davis refers to as 'the oppression model' emphasises women's shared experiences, and locates women's oppression within the institutional power relations of heterosexuality and patriarchy, which continue to reproduce and reinforce hegemonic systems of male domination and female subordination within contemporary society. Sylvia Walby, for example, defines patriarchy as 'a system of social structures, and practices in which men dominate, oppress and exploit women' (Walby, 1989: 214; *also see* Dworkin, 1989; Mackinnon, 1989; Wolf, 1991; Faludi, 1991; Morgan, 1991).

According to those who adopt the 'beauty-as-oppression' perspective, women's preoccupation with appearance is a result of the commercial exploitation of women within the beauty and cosmetic surgery industries. These analyses suggest that the beauty industry has created and promoted an impossible standard of beauty for women - an ideal that women are encouraged to unquestioningly accept and recreate in their own lives<sup>17</sup>. Implicitly, this perspective aligns commercial interest in women's bodies with an on-going patriarchal tradition of institutional control over women and their bodies. This analysis tends to silence women who have cosmetic surgery, and suggests that feminists have nothing more to say on the matter. The alternative is an approach to the feminist analysis of cosmetic surgery and the construction of beauty which considers complexity, which questions whether women are indeed cultural dupes and explores the ways in which action on the body is a potential source of empowerment as well as control.

Increasingly the oppression model is being challenged by feminist analyses which use discourse analysis to explore different understandings of cosmetic surgery. Concepts of femininity are seen as discursively constructed through language, texts, images, institutions and subjectivities. Davis provides the following definition of this alternative model:

...the unified category "woman" is abandoned in favor of a diversity of femininities. Femininity becomes a (discursive) construction with power implicated in its construction...With the advent of Postmodernism...(the oppression model)...becomes unacceptable on the grounds that there is no authentic female self awaiting liberation... Following Foucault, the female body comes to be seen as a cultural text through which femininity in all its diversity is constructed - in scientific discourses, medical technologies, the popular media and everyday common-sense (Davis, 1991: 26).

This perspective emphasises differences between women, and the major focus moves from the material body to a focus on language. Postmodernists

<sup>17</sup> See Wolf (1991: 27-57) and Kanin (1990: 9-10).

problematise the idea that consciousness-raising will reveal a 'natural' femininity, because what is 'natural' is constructed as such within culture. Unlike Davis, I do not wish to dichotomise the oppression model in opposition to the discourse model. Rather my emphasis is on exploring the contradictions and ambiguities involved in the cosmetic surgery field without elevating either the body or discourse as determinative.

Women's subjectivity and experience of the body are missing in most feminist accounts of cosmetic surgery. I argue that feminist analyses of cosmetic surgery must take into account the historical and cultural contexts in which social practices are embedded. Often when feminists have paid attention to the way women talk about cosmetic surgery, they have privileged individual stories of oppression relative to expressions of empowerment or pleasure. The former have been interpreted as 'true' reflections of social reality, while the latter when discussed, are located within a 'false conscious model'. This cosmetic surgery as false consciousness approach is unhelpful because it is unable to account for pleasure, agency, and experience. According to Vance, feminists must develop ways to integrate the body:

into a social construction frame, while still acknowledging that human experience of the body is always mediated by culture and subjectivity, and without elevating the body as determinative (Vance, 1992: 140).

According to Elizabeth Grosz, Luce Irigaray is also critical of the oppression model. Irigaray rejects the modernist project of equality, which she equates to a feminism of 'sameness'. Instead Irigaray advocates a feminism concerned with the politics of difference and specificity, a feminism which recognises differences between and within the masculine and feminine categories assigned to both men and women. Irigaray's object of analysis is the lived body, the body that is marked, inscribed and made meaningful through its discursive construction and social reproduction. For Irigaray the body is a socially inscribed, historically marked and reflexively<sup>18</sup> significant product (Grosz, 1987: 140).

According to the oppression model, elective cosmetic surgery performed by cosmetic surgeons is generally constructed as 'bad', 'unnecessary' and 'illegitimate', and the women who undergo these procedures are often considered vain, frivolous, narcissistic and self indulgent (Burk et.al., 1985:

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<sup>18</sup> Grosz uses the terms 'psychically and interpersonally significant product' (1987: 140). However, I think the sociological idea of reflexivity expresses this notion less awkwardly.

270-271; Wolf, 1991:234 ;Young, 1990b: 202; Bordo, 1991: 108-110; 1993b: 288; 1993c:188-189). Kathryn Pauly Morgan, uses various metaphors of oppression to describe the cultural normalisation of elective cosmetic surgery as not simply the creation of:

...beautiful bodies and faces, but white, Western, Anglo-Saxon bodies in a racist, anti-Semitic context... (Morgan, 1992: 36).

In fact if we run all the forms of oppression Morgan uses to describe cosmetic surgery together in one paragraph, we could come up with a statement that suggests, for example, that the transforming of oneself as a woman through cosmetic surgery is almost always affected by the dominant culture of the 'Other', which is 'male-supremacist', 'racist', 'ageist', 'heterosexist', 'anti-Semitic' and 'class biased' (Morgan, 1992: 36, 38).

On the other hand, plastic or reconstructive surgery performed by plastic and reconstructive surgeons is considered 'good', 'necessary' and 'legitimate'. The people who undergo these procedures attract none of the negative connotations associated with having cosmetic surgery. Morgan appeals to the collective power of women as consumers to affect market conditions by refusing to insert themselves into the discourses surrounding cosmetic surgery. For Morgan, the act of refusal might have the added consequence of forcing cosmetic surgeons back into providing legitimate plastic and reconstructive surgery, (re)converting these surgeons into healers (Morgan, 1991: 42).

Naomi Wolf also constructs cosmetic surgery as plastic surgery's illegitimate antithesis. For Wolf, it is the cosmetic surgeons who 'must create a client pool where none biologically exists...as opposed to plastic surgeons who specialise in burns, trauma, and birth defects...' (Wolf, 1991: 234). Specifically, both Wolf's and Morgan's analyses set up a binary opposition between cosmetic and plastic surgery, the construction of which warrants further investigation. In New Zealand and elsewhere, medical disputes over territory have meant plastic surgeons have deliberately cultivated a distinction between those (hospital trained and based) plastic and reconstructive surgeons who are members of the New Zealand Foundation For Cosmetic Plastic Surgery, and (clinically trained and based) cosmetic surgeons who do not have the appropriate medical qualifications to become members of the Foundation<sup>19</sup>. In New Zealand:

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<sup>19</sup> This debate can be seen as a dispute over access to clients and potential clients. See Chapter Four Section 3 for a more comprehensive discussion of this.

Only 28 specialists (including one woman) are registered by the Medical Council as plastic surgeons...They are qualified to perform any kind of surgery on the face and body...The trouble lies with the medical practitioners who have taken up cosmetic surgery, attracted by the money to be made, with little or no formally recognised training in the field (*Reader's Digest*, October, 1992).

This distinction is encouraged, even though the Plastic surgeons belonging to the Foundation also offer to women the same cosmetic surgery procedures as the cosmetic surgeons. Two Christchurch plastic surgeons, (who are members of the New Zealand Foundation For Cosmetic Plastic Surgery), advertise that they are available to 'discuss any aspect of cosmetic surgery including liposuction'<sup>20</sup>. The importance of internal disputes and professional boundaries is taken up in a discussion of 'the political economy of cosmetic surgery' in Chapter Four<sup>21</sup> of the thesis.

The discourses and practices which construct an opposition between social responses to differences in appearance are reflected in understandings of cosmetic surgery and reconstructive surgery. For example, plastic surgery definitions of reconstruction go beyond functional repair to the achievement of a cosmetic result<sup>22</sup>. It is also useful to recognise that both cosmetic and reconstructive surgery are responses to difference and the rejection of difference in Western industrialised societies. Cosmetic surgery is based on the normalisation of seemingly impossible standards of female beauty, while plastic and reconstructive surgery is based on the restoration of 'normal' appearance in severe trauma survivors. If society was more accepting of difference then trauma survivors need not be constructed as requiring correction, improvement and restoration. The distinction between plastic and cosmetic surgery has to be seen as discursively constructed. It does not refer to obvious material differences in these procedures. The way plastic surgeons discuss distinctions between plastic and cosmetic surgery opens up further consideration of this binary opposition and is pursued in more detail in Chapter Four<sup>23</sup> of the thesis.

<sup>20</sup> See Figure 2.1 page 40. Christchurch *Yellow Pages*, 1992 p. 249 (Telecom NZ ).

<sup>21</sup> See Section 4.3.

<sup>22</sup> See the discussion of differences between reconstructive and cosmetic surgery in Chapter Four Section 4.3.

<sup>23</sup> See Section 4.3.

## 2.7 FEMINIST ALTERNATIVES AS CULTURAL CONSTRUCTIONS

Foucault argued that repression always generates its own forms of resistance (1978: 101). When feminists speak into existence cultural practices that have previously been considered deviant, what they are doing is attempting to normalise those practices and discourses. Women have in this way attempted to normalise abortion and lesbian and bisexual intimacy. Morgan suggests that elective cosmetic surgery has been previously considered suspicious, sleazy, secretively deviant and pathologically narcissistic. Bringing cosmetic surgery into popular discourse has important political implications for women, because it allows for the possibility that the social meanings and power relations within which the discourses and practices of cosmetic surgery are inscribed may be challenged and alternative resistant or critical discourses produced.

More importantly, however, when feminists are resistant or critical of women's decisions to use cosmetic surgery to conform to a 'traditional' image of femininity, they often attempt to construct alternative feminist discourses about what is 'natural' for women. These discourses neglect to recognise that the 'natural' images being constructed as alternatives for women are in themselves normalising images of women. It is important to look at feminist alternatives to cosmetic surgery as social constructions. We need to reflect critically on the construction of feminist alternatives and what counts as appropriate ways to rework 'the body' within different contexts.

Morgan offers the act of 'refusal' (Morgan, 1991: 41) as one solution to the colonisation and exploitation of women's bodies within the discourses and practices surrounding cosmetic surgery. This analysis implicitly presents the body that has not been altered through cosmetic surgery as 'natural'. It does not acknowledge how this body is inevitably situated within relations of power that also construct it as masculine, feminine, old, beautiful, fat, pathological, diseased, effeminate, butch or ugly. What feminists who analyse beauty as oppression tend to ignore is that cosmetic surgery reconstructs the already constructed and reimagines the already imagined (Biersack, 1989: 77). When women and men voluntarily engage in the discourses and practices surrounding cosmetic surgery, this could be seen as an act of resistance to the involuntary imposition of some of these alternative sets of discourses on their bodies. For example, while the majority of people who use cosmetic surgery do so in order to approximate the idealised images of masculinity or femininity produced

within representational culture, cosmetic surgery can also be used to challenge those masculine and feminine ideals.

Michael Jackson is one who has not used cosmetic surgery to make himself more masculine. Jackson derives pleasure from using cosmetic surgery, make-up and fantasy to actively construct his appearance as androgynous or gender neutral. However, Jackson is also a problematic example - is the modification of his nose so that he conforms to 'white norms' of attractiveness a play with plasticity or a response to racist normalisation, or both? Jackson himself defends his surgery by saying he is not denying his ethnicity any more than 'white folks' who pay to get a tan<sup>24</sup>.

Similarly, men and women who use cosmetic surgery to change their gender identity are challenging fundamental modernist assumptions that the binary oppositions constituting male/female, masculine/feminine, nature/culture are naturally determined. A Christchurch newspaper recently featured an article about a woman who had reconstructed herself as androgynous by undergoing a hysterectomy and having her breasts removed. In the article (s)he claims (s)he is 'living proof of the third sex'. Christie sought surgery because (s)he "felt I could no longer live in that body", (s)he describes waking up without breasts as, "the happiest moment of my life" (*The Press*, 20/06/92). At the same time Christie's resistance reinforces the notion that challenges to conventional femininity and masculinity have to be associated with changing the genitals and/or the breasts. Christie challenges categorisation but maintains the association of bodies with behaviours and thus notions of the relation between the physiological and social identities. For the feminist theorist then, attempting to make sense of cosmetic surgery is:

...an irrevocably dilemmatic situation: Problem and solution, oppression and liberation, all in one (Davis, 1991: 30<sup>25</sup>).

According to Davis, neither the oppression model or Susan Bordo's (1990) discourse model provide analyses of cosmetic surgery that do justice to questions that concern women's active and knowledgeable involvement in practices that are also detrimental and/or degrading to them. She argues:

First it rests on a conception of power that is devoid of agency...Second, a "cultural dope" approach reinforces dualistic conceptions of the female body...women's active

<sup>24</sup> Source: *The Oprah Winfrey Show*, Michael Jackson Special, TV3 18/02/93.

<sup>25</sup> Capital 'p' in 'Problem' in the original.

and lived relationship to their bodies seems to disappear in feminist accounts of beauty. Cosmetic surgery becomes a strangely disembodied phenomenon, devoid of women's experiences, feelings, and practical activities with regard to their bodies...Third, an approach that treats women as "cultural dopes" restricts the possibility for feminist analysis and intervention (Davis, 1991: 23).

Susan Bordo (1993c) has recently responded to Davis's critique of her position on cosmetic surgery. Her discussion of subjectivity, embodiment and resistance provides an important summary of the way gender is enacted through language, performance and normative cultural hegemony. Bordo distances herself from the oppression model and can be interpreted as agreeing with aspects of Davis' analysis in her theoretical conception of femininity as both conformity and resistance:

...power relations are never seamless, but always spawning new forms of culture and subjectivity, new openings for potential resistance to emerge...Modern power relations are thus unstable; resistance is perpetual and hegemony precarious (Bordo, 1993c: 192<sup>26</sup>).

Bordo critiques feminist analyses of femininity as oppression for over-emphasising patriarchal control. She suggests that the oppression model and feminist attempts to recover the 'natural' body fail to give adequate consideration to the disruptive potential of pleasure, subversion, agency, creativity and resistance. For Bordo, the oppression model 'under-estimates the unstable nature of subjectivity and the creative agency of individuals' (Bordo, 1993c: 193). For instance, Bordo (1990) provides an analysis of anorexia nervosa as an example of both conformity and resistance to ideals of femininity. Her interest lies in exploring the contradictions and ambiguities associated with the 'cultural management of female desire' (Bordo, 1990: 88). To date Bordo has not applied her analysis of anorexia nervosa to an exploration of the contradictions involved in cosmetic surgery. She places little value on the transgressive potential of cosmetic surgery, nor the possibility that individual women may use it as a form of resistance to the cultural normalisation of the body.

While Bordo seeks to make visible the creative agency of individuals, her focus on normalisation rather than resistance means that she moves close to a construction of women who choose cosmetic surgery as 'cultural dupes'<sup>27</sup>. For Bordo:

<sup>26</sup> Also See Bordo, 1992: 172

<sup>27</sup> Also see Bordo, 1993b: 295-297.

...normalisation' is still the dominant order of the day, even in the postmodern context, and especially with regard to the politics of women's bodies (Bordo, 1993c: 183).

In addition, her analysis of women who 'choose' cosmetic surgery as a form of 'voluntary' 'subordination' is suggestive of hegemonic compliance to patriarchal ideals of femininity. For Bordo:

...female subordination...is reproduced 'voluntarily' through self-normalisation to everyday habits of masculinity and femininity (Bordo, 1993c: 191).

Although Bordo argues that it is not her intention to construct women who 'choose' cosmetic surgery as 'cultural dupes' (Bordo, 1993c: 188), her disclaimer does not resolve this fundamental tension within her analysis. So, while Bordo wishes to distance herself from the oppression model and to emphasize forms of agency, and while she explores the agency of women with eating disorders, this analysis is not applied to women who have cosmetic surgery.

Both Wolf and Morgan consider cosmetic surgery to be a form of institutionalised (medical) violence against women.<sup>28</sup> Their analyses of cosmetic surgery as pathological conformity, embedded in a repressive social and political context, emphasise the dominating, controlling and objectifying nature of medical technologies. Within this analysis, historical forms of patriarchal domination are continued through modern technologies of the body. Unlike the analyses of medical domination provided by both Morgan and Wolf, Jana Sawicki's application of the Foucauldian notion of disciplinary power, to an analysis of new reproductive technologies, incorporates a recognition of the ambiguities and contradictions surrounding women's voluntary engagement in medical technologies. This analysis can also be applied to a discussion of the normalising and empowering aspects of cosmetic surgery. In addition Sawicki is critical of the tendency to demonise medical technologies and the 'men' who design and implement them. According to Sawicki:

Women are portrayed either as innocent and ignorant victims of the medical establishment or as unwitting colluders in a horrifying extension of patriarchal control over women's bodies. In short, women's consciousness is reduced to false consciousness (Sawicki, 1991: 73).

<sup>28</sup> For example, Wolf (1991) describes beauty practices as 'self-mutilation' (p. 230), cosmetic surgery as 'war', 'torture' (p. 256) 'human rights abuse', 'political weapons' (p. 257), 'violence' (p. 258) and 'coercion' (p. 259) and women who have cosmetic surgery as "scalpel slaves" (p. 255) and masochists (p. 258). Morgan describes modern (cosmetic surgery) bio-technologies as: 'invading' (p. 30), 'control' 'exploitation', 'destruction' (p. 31) 'alienating', (p. 39) and 'coercion' (p. 41).



Sawicki suggests that analyses of medical technologies as violence tend to construct women as passive subjects and not potential activists. The issues raised in Sawicki's discussion of new reproductive technologies are relevant to an analysis of cosmetic surgery. Feminist critiques of both cosmetic surgery and reproductive technologies contain analyses of power that are repressive. The repressive model of power obscures the multiple meanings of cosmetic surgery and the contradictions associated with the technological transformation of women's bodies. For Sawicki, analyses of patriarchal power, as operating through violence, objectification and repression, are unable to explain women's voluntary engagement in the discourses and practices of for example in-vitro fertilisation or cosmetic surgery (1991: 85).

The major advantage of the disciplinary model of power is that it provides an analysis of cosmetic surgery that emphasises normalisation and resistance instead of violence, repression and oppression. Cosmetic surgery does not control bodies through violence or coercion, but rather through what Sawicki has identified as 'inciting desire', attaching female identities to particular representations of femininity and by presenting medical solutions to specific 'problems' of shape and form. Cosmetic surgery is a disciplinary technology that renders the body simultaneously empowered and docile. As with new reproductive technologies, cosmetic surgery offers benefits that many women and men perceive as beneficial and enabling (Sawicki, 1991: 85). Sawicki's analysis does not obscure the normalising and disciplinary aspects of medical technologies; but it does suggest ways in which cosmetic surgery can be examined as both normalising, enabling and empowering.

## 2.8 SUMMARY

The purpose of this chapter has been to unpack the relevant aspects of Foucauldian theory, and to explore how it might be applied to an analysis of cosmetic surgery. In order to focus on the gendered construction of the body, feminist appropriations of Foucault have been considered (I have argued that, although women are those targeted through cosmetic surgery technologies, these technologies cannot be analysed simply in terms of patriarchal conspiracy, violence, coercion, objectification and repression.) A case has been made for analyses of cosmetic surgery which look at the contradictions and ambiguities associated with women's engagement in the discourses and practices of cosmetic surgery. This entails balancing analyses of cosmetic surgery as normalisation with a recognition of the creative agency of

individuals. The next section of the thesis will explore these issues through an analysis of the discourses and practices of cosmetic surgery clients.

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Figure 2.1 Cosmetic Surgery Advertisements For Liposuction (See page 34). Source: Christchurch *Yellow Pages* (1992: 249).

## CHAPTER THREE

### BEAUTY AND THE BREAST

"Corsets and narrow waists should be regarded as absurdities akin to the Chinese bandages and stunted feet, and be shunned by all possessed of a few grains of common sense. If Dame Nature has cast us in a generous mould, let us rejoice, and not attempt to dwarf her handiwork."

- Kate Sheppard<sup>1</sup>

Throughout history  
the body has been contrived into shapes,  
by steel bars, whale bone strapping...  
Today's woman,  
with her new demanding role,  
has formed a new shape,  
a natural shape.

*Design*<sup>2</sup>

This chapter begins with a discussion of the range of external and internal technologies and practices employed by women to transform and shape their bodies. It suggests that the external control of the body has been augmented by the internal controls of dieting, exercise and cosmetic surgery. The nineteenth century practice of corsetry and tight-lacing is discussed as an historical example of the way in which the physicality of the body was externally controlled in accordance with Victorian ideals of femininity. The discussion of corsetry and tight-lacing is then compared within an analysis of the discourses and practices surrounding modern forms of cosmetic surgery.

The analysis of cosmetic surgery draws on interviews with women who have undergone various surgical procedures on their breasts, including mastectomy, reconstruction, reduction, augmentation and enhancement. It considers how individual women might adopt or resist cosmetic alteration or reconstruction. Through attention to the accounts of women who have breast surgery, the chapter explores the problematic relationship between agency, subjectivity, authenticity and cultural texts. The final section explores how analysis of this talk about women's experiences of breast surgery challenges dominant

<sup>1</sup> Lovell-Smith, Margaret (1993: 169): *The Woman Question: Writings by the Women who Won the Vote*.

<sup>2</sup> Tabrizian, Mitra (1990), *Correct Distance*. (Photographic essay on 'Governmentality' and 'Surveillance', no page numbers in the book).

understandings of these practices within popular culture. It problematises recent feminist theories about the body, femininity and cosmetic surgery and suggests there is a need for feminist theory to develop alternative responses to these discourses and practices.

### 3.1 EXTERNAL VS INTERNAL CONSTRAINT

Sharlene Hesse-Biber (1991) suggests there has been an historical shift in the technologies and practices employed to transform and shape women's bodies. This transformation has involved a departure from the external constraints of nineteenth century corsetry towards internal or self-imposed controls exacted by modern forms of cosmetic surgery, dieting and exercise. Hesse-Biber suggests the technologies and discursive rules that inform both these practices of femininity are a result of an historical transformation of women's bodies into commodities through a marriage of capitalistic and patriarchal interests (Hesse-Biber, 1991: 173,177). In Chapter Two<sup>3</sup> I explored how corporeal knowledge/power is deployed through disciplinary practices which target the body; these practices become self-regulating through establishing norms and creating desires. For Hesse-Biber, many women today achieve the new feminine idealised body shapes, not just by external control of the body (the purchase of a corset or girdle), but through internal or self-imposed controls, such as those involved in dieting, exercise and cosmetic surgery (Hesse-Biber 1991: 177).

Hesse-Biber's analysis relates to women of a specific time and space, that of late twentieth century Western women. However, the continuing use of bras, cosmetics, and hair-styling among Western women suggests the external control of the body has not been replaced, as Hesse-Biber suggests, but rather augmented by these internal self imposed controls. In the following section the example of corsetry and tight-lacing is used to problematise some of the dominant understandings of this historical practice. The analytical framework used in the discussion of corsetry and tight-lacing is then applied to cosmetic surgery. Attempts are made to disrupt interpretations of women who engage in the discourses and practices of cosmetic surgery as misguided, cultural dupes.

There are striking parallels between Victorian advertisements for corsetry and contemporary advertisements for surgical and dietary techniques which play on

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<sup>3</sup> See Section 2.4

ideals of femininity, and construct the female body as in need of control, shaping and transformation. Currently women in Western industrialised societies are invited to transform themselves from within through dieting and exercise regimes or by cosmetic surgery. It appears that controlling and shaping the body was also important to many Victorian women; the technologies available to them most commonly involved the external constraints of stays and corsets. In this way the physicality of the body was controlled and shaped in accordance with prevailing Victorian ideals of feminine beauty.

These ideal Victorian shapes are indicated by nineteenth century advertisements for corsetry which suggest that the physical size and shape of the body need not affect how the body appeared once dressed and corseted. The desired eighteen inch waist, slim hips and anchored or immobilised bust was achieved through the superior cut or 'fit of the Lady's Dress or Costume'<sup>4</sup> rather than through women's attempts to produce this effect through diet and exercise. The outer garments and the dress-sense of the wearer were seen as ultimately determining the female figure. In the nineteenth century, having a good tailor, (rather like having a good cosmetic surgeon today), was constructed as the only requirement for achieving the feminine ideal. For example this advertisement for a range of Victorian corsets promotes them as 'model types of female form':

Upon the shape of the Corset entirely depends the accurate fit of a Lady's Dress or Costume ... These Corsets are ... acknowledged model types of female form ... cut in exquisite proportions ... the fabric and bones are adapted with marvellous accuracy to every curve and undulation of the finest type of figure. The Corsets also give great support, and they fit so accurately and comfortably that a very small size can be worn without the slightest injury to the figure' (cited in Wilson, 1985: 98).

For over two hundred years the corset was constructed as an essential component in the creation and maintenance of fashionable female forms. In the 1890s the uncorseted body was thought to be 'unnatural', and non-corseted women were described as shapeless and masculine. Tollerton's (1992) biography of Ettie Rout, an early New Zealand advocate for dress reform, describes Ettie's uncorseted figure in following way:

...her Amazonian image was exacerbated by her shape. Where other women went in at the middle, she did not. She seemed to have no figure; in fact it was simply that she had no corset. Tall, square-shouldered, fit and fast-moving, she seemed very muscular

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<sup>4</sup> Wilson 1985: 98

compared with the fleshiness of the fashionable female figure of the day (Tollerton, 1992: 41).

In England the Rational Dress Society advocated a hygienic, artistic and rational style of dress based upon considerations of health, comfort and beauty. Its members protested against the wearing of tightly-fitting corsets and crinolines which were thought to be ugly and deforming. The Rational Dress Society argued against the introduction of any fashion in dress that either deformed the figure, impeded the movement of the body, or in any way tended to injure health (Newton, 1974: 2, 117). Despite the activities of the Rational Dress Association in New Zealand, corsets were still popular in the 1890s:

The whalebone corset was still viciously nipping in waists and boned collars still strangled necks so effectively that women had to turn their whole upper body to look over their shoulder (Tollerton, 1992: 41).

David Kunzle (1982) set out to challenge what he described as a 'myth' that tight-lacing was seen as 'universally fashionable and universally harmful to women' (Kunzle, 1982: xix). According to Kunzle, the Rational Dress Society's advocacy for bodily emancipation from the tightly laced corset was embedded in an ideology of control rather than liberation for women. Excess in corsetry, sport, education and politics were bracketed as equally unhygienic and 'unnatural' for women. According to the English dress reformers, artificial cultivation of the mind and/or body produced feminine anxiety, fatigue and listlessness (Kunzle, 1982: 43). The discourses of the Rational Dress Society can be interpreted as 'patriarchal' attempts to limit women's economic, legal, political, social and sexual equality/autonomy. Kunzle suggests that dominant twentieth century understandings of tight-lacing, which construct it as an 'irrational', 'foolish' and 'vicious' practice, are severely limited because they emerged out of the discourses of the Rational Dress Society, and reflect the conservative opinions of a small group of hostile and vociferous Victorian males. According to Kunzle, these Victorian examinations of tight-lacing omit from the historical record the physical and erotic pleasure that many Victorian women derived from this practice. Moreover, Kunzle suggests conservative male arguments against the use of corsets and stays have been adopted unproblematically in some modern feminist critiques of corsetry and tight-lacing (Kunzle, 1982: xvii).

Kunzle argues that corsets were frequently described as 'whalebone prisons', and Victorian women who tight-laced were thought to be deviant and

transgressive. For Kunzle the practice of tight-lacing is fraught with contradictions and ambivalence, the corset, 'undeniably a symptom and symbol of female oppression' was also a means of protest:

...the "bondage" of tight-lacing was an expression not of conformity with fashion, which never condoned it, but against conformity with the "fashionable" (i.e. culturally dominant) role of the socio-sexually passive, maternal woman...The tight-lacers were abused out of fear of women, and of female sexuality. The abuse was part of the Victorian repression of sexuality, and particularly female sexuality, which was regarded as subversive of the social order. Tight lacers were, like witches and prostitutes of old, social and sexual scapegoats (Kunzle, 1982: xviii).

Elizabeth Wilson (1985) has also suggested that contemporary feminists too readily construct the nineteenth century practice of corsetry and tight-lacing as an example of women's masochistic and narcissistic submission (or hegemonic compliance) to a patriarchal fetish with female bodily constriction. Within this analysis corsets are historical artifacts symbolising the general subordination of women. Wilson suggests this analysis is too simplistic; she offers a more complex explanation of these practices which involves reconstructing Victorian women as active and embodied historical actors. She argues that the discourses and their experiences of these practices can be seen as containing contradictory elements of oppression, subordination and conformity as well as security, resistance, empowerment, transformation and possibility (Wilson, 1985: 97-99)<sup>5</sup>.

Wilson (1985: 99), like Kunzle, suggests that because tight-lacing was widely considered an immoral and unnatural practice, it could be used to express a covert form of rebellion, social aspiration and aggression. Thus, Victorian dress can be seen (or read) as an extreme way of immobilising women's physical movement and as a way of transforming appearance through technologies over which women had control - technologies used by the women as mechanisms to protect against inappropriate invasions of their personal space, and as a means of achieving social distance from men<sup>6</sup>.

In Chapter Two<sup>7</sup> I suggested that discourses are ideologies in use. The contradiction and confusion surrounding the Victorian practice of corsetry and

<sup>5</sup> See in particular her discussion of Kunzle p. 99.

<sup>6</sup> Susan Brownmiller (1984) also hints that women may have used the corset as a form of protection: 'I suspect the *true reason* women put up with the...corset for so many centuries, abandoning it finally when the bra made its appearance, was that the majority of them felt more at ease physically - *better armored*, so to speak - when their breasts were immobile and firmly contained' (p. 40, italics my emphasis). See also the use of the crinoline in Jane Campion's film 'The Piano'.

<sup>7</sup> See Section 2.2.

tight-lacing is reflected in the analyses of Hesse-Biber, Kunzle and Wilson who consider corsetry to be respectively oppressive, subversive and contradictory. Tollerton's historical analysis suggests that tight-lacing was an expression of conformity; consequently non-corseted women were considered shapeless and masculine. Victorian advertising for corsetry constructed corsets as model types of female form, while Victorian discourses against tight-lacing, like those provided by the Rational Dress Society, considered it to be an unhygienic, irrational and ugly practice. Interestingly, Victorian debates about corsets parallel contemporary controversies surrounding cosmetic surgery and body building. Cosmetic surgery and professional bodybuilding are often constructed as dangerous, oppressive and exploitative practices. At one level these discourses are deployed to recover the 'natural' body and to reveal the repressive social, economic and political contexts in which these practices are embedded. However, at another level they can also be interpreted as attempts to deny women's physical or sexual power and to limit their lifestyle choices, and therefore, access to the social status and economic rewards that might result from these practices.

According to Wilson (1985: 95), 'fashion is ... a continuous dialogue between the natural and the artificial'. For Kate Sheppard the natural body was the ideal body and women who sought to transform their shape through wearing corsets were those without commonsense - in contemporary terms 'cultural dupes'. Kate Sheppard, New Zealand's most famous suffragist, constructed the corseted body as 'unnatural', by implication defining the uncorseted body as the 'natural' body. Like some contemporary feminists analysing cosmetic surgery, Kate Sheppard constructed women who wore corsets as lacking common sense or intelligence. This discourse, like some contemporary feminist discourses which link the essential feminine to the 'natural' body, effaces the extent to which meanings codify and define the material body. This play on the 'natural' and the 'artificial' is also an obvious feature of the discourses and practices surrounding cosmetic surgery.

### 3.2 NATURE AND ARTIFICE

Victorian corsetry and the practice of tight-lacing can be compared with the external use of 'bras' and 'falsies' to constrain and mould the breast in the mid twentieth century and the invasive use of cosmetic surgery to enhance, shape and reconstruct the breast in the mid and late twentieth century. In a recent article on cosmetic surgery, Joanne Finkelstein (1991) suggests that physical



appearance has less to do with 'nature' and more to do with the availability of techniques that can reshape and fashion the body on demand. For Finkelstein this triumph of culture over 'nature' has resulted in an increasingly utilitarian attitude towards the body:

...the greater availability of surgical procedures and various reshaping techniques,...in conjunction with the social influences that have emphasized appearance, have helped to forge a cultural narrative or backdrop against which the human body is viewed more like a commodity which can be shaped, styled and reconstructed to approximate more closely the individual's ideal form (Finkelstein, 1991: 88).

Finkelstein's analysis suggests new surgical technologies have produced an ideological shift in the discourses and practices which describe and inscribe the shaping and transformation of women's bodies. This change has involved a shift in attention from the material, autonomous body towards a consideration of the body as a commodity able to be moulded and transformed (Finkelstein 1991: 87). The idea of a plastic and malleable body is compatible with fashions in cosmetic surgery procedures which parallel changes in ideals of femininity. Finkelstein suggests breast enlargement was popular in the 1980s whereas breast reduction was more popular in the 1970s (1991: 88). She assumes the plastic and malleable body is a development specific to the time and space of late capitalism (1991: 87-89, 189). However, the discourses surrounding the Victorian practice of tight-lacing also assumed a plastic and malleable body that was able to be moulded and transformed through the use of corsets, stays and a well tailored costume. In addition, Finkelstein suggests that the surgically modified body is less 'natural' than the unmodified body (1991: 189). Like Kate Sheppard, who rejected the artificiality of the corseted body, Finkelstein's analysis tends to assume the existence of an essential 'natural' female body. This discourse effaces the extent to which physical appearance is constructed differently according to age, ethnicity and gender.

The constructed opposition between naturalness and artifice with respect to femininity can be seen in advertisements for women's cosmetics, beauty products and cosmetic surgery which play on the contradiction between the natural and the artificial. Table 3.1 provides a selection of magazine extracts that suggest parallel ways of understanding cosmetic surgery, clothing, facial peels and makeup. These advertisements contain contradictory messages about achieving natural beauty either through the external application of beauty products or through the use of invasive cosmetic surgery technologies. Both cosmetic surgery and makeup are presented as 'natural' solutions to specific problems of body shape and form.

<p>Cosmetic Surgery A new body for \$15,000</p>	<p>\$20,000 worth of fabulous clothes (<i>Cosmopolitan</i>, May 1993).</p>
<p>NEW SKIN FOR OLD? Skim off the skin's upper layers and new, younger-looking skin grows back in its place. That's the idea behind skin resurfacing, which unlike a facelift alone, can freshen up sun-damaged skin, remove blotches, sallowness and smooth out fine lines...</p>	<p>Brilliant Disguise With the latest corrective makeup perfect skin is only a few minutes of creative camouflaging away... RED, BLOTCHY SKIN Green neutralizes red skin tones... SALLOW SKIN Purple cancels out yellowness in the skin...  ...moisturizes and soothing herbal ingredients, such as chamomile and aloe vera, reduce tired puffy eyes and smooth out fine lines...</p>
<p>Would you wear last years nose? Then don't ask for one. Barbie Doll bobs have moved over in favour of stronger, more natural noses.</p>	<p>Forget winter's dark and smouldering eyes...lighter eyeshadows - from dusty pink to taupe, and silvery blues to aquamarine - are the new, paler shades to look for.</p>
<p>Brow lifting...tames the tired look created by horizontal forehead lines and drooping eyebrows...</p>	<p>Revamp your brows into the arched and darkened shape of the season, remembering this golden rule as you take out your tweezers: accentuate but don't alter the natural shape... (<i>Cleo</i> September 1991).</p>
<p>Facelifts now are more natural and longer lasting... (<i>Mode</i>, Oct/Nov 1993).</p>	<p>Perfect lipstick It's super long-lasting (<i>Cleo</i>, August 1993).</p>

Table 3.1: Femininity work as nature and artifice; textually mediated discourses of 'natural' rectification.

Canadian Sociologist Dorothy Smith (1990) uses the notion of discourse to refer to a 'field' in which 'relations and courses of action are mediated by symbolic forms' and expressed in texts, such as those presented in advertising and the media (1990: 162). Smith identifies discourse as an ongoing intertextual, social and commercial process embedded in, and thereby contributing to, the organisation and interpretation of cultural relations and practices (1990: 162-164). According to Smith's analysis, the socially constructed (feminine) body can be read as a cultural text, within which discourses of femininity 'address a complex of actual relations (and practices) vested in texts' (1990: 163).

The influence of the media is pervasive in constructing an image of the female body as spectacle. Through advertising and editorial copy we gain access to the discourses of the beauty experts and the cosmetic surgeons, who, along with images of models - such as Rachel Hunter, Elle MacPherson, Claudia Schiffer and Cindy Crawford - implicitly construct for women certain ideals about what images are most pleasurable and desirably feminine (Bartky, 1988 74). The previous advertisements market 'natural' 'rectification'<sup>8</sup> of the skin or body through the use of cosmetic surgery or makeup. The reader is constructed as needing these products and services in order to approximate to the standards of femininity which are in part set by the images produced by the advertisers (Du Plessis, 1992: 3).

### 3.3 BREAST SURGERY AS NATURE AND ARTIFICE

The external use of the breast prosthesis and the 'superbra', and the internal self-imposed controls of cosmetic surgery, diet and exercise employ technologies to artificially sculpt, transform, mould and restore the breast. The discursive practices surrounding these technologies play on the use of artifice to construct a more 'natural' shape. For example the names given to the different brands of silicone-gel breast implants - the Natural Y, the Vogue, the Replicon, the Optimam and the Meme - play on linguistic forms which suggest an association with fashion, the natural, the ideal and reconstruction. In the previous examples, the 'Natural Y', 'Replicon', and the 'Meme' (meaning in French 'identical' or 'same') are derived from linguistic terms which suggest they may replicate, are identical to, or reconstruct the 'natural' breast. In English 'vogue', a word most commonly associated with haute couture fashion,

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<sup>8</sup> See, Smith (1990: 185).

suggests more fashionable implants/breasts, and 'Optimam' is obviously a play on optimum and mammary and could be interpreted as meaning ideal breasts. Importantly these implant brand names are deployed to efface the distinction between the natural and the artificial, suggesting a more 'natural' breast shape can be achieved through the use of these artificial products.

In the West, breast augmentation and reconstruction are the most popular forms of cosmetic body surgery. It is used not only for reconstructions 'following mastectomy, but for cosmetic reasons alone' (Finkelstein, 1991: 101). Finkelstein argues that psychological analyses of cosmetic surgery fail to acknowledge its importance as a social practice tied to the cultural definitions of the body and the social construction of femininity:

These (psychological) observations omit from consideration the sociological value placed on stereotypical appearance and, in particular, *breasts which are commonly regarded as an icon of femininity* (Finkelstein, 1991: 102, italics my emphasis).

Breast surgery can be seen as a social process that produces meaning. Finkelstein's structural feminist analysis of cosmetic surgery suggests that women who undergo breast surgery are *located* in discursive practices which structure and institutionalise certain social relations of power/knowledge. Implicitly Finkelstein provides a 'one way street' analysis within which individual women who have cosmetic surgery are constructed as passive casualties of larger external social processes.

This analysis becomes highly problematic when used to explore cosmetic surgery through the accounts women offer about their experiences, and the body shapes women reproduce or desire. Women who have cosmetic surgery often see themselves as using technologies over which they have some measure of control, and the majority of women who undergo aesthetic transformation are happy with the results of their surgery. This suggests that it might be useful to explore cosmetic surgery as a cultural practice tied to particular social relations of femininity, mediated by discourses and texts, *within which women are engaged as active subjects and agents*. In the conversations I had with women who had experienced cosmetic surgery they explored how feminine aesthetics influence the feelings they have about themselves and their bodies. They engaged problematically with their individual decisions to have cosmetic surgery and they acknowledged the way ideals of femininity are constructed and circulated within the wider culture. The following sections consider different forms of breast surgery. In particular radical mastectomy engages

most women in the discourses and practices of 'rectification'<sup>9</sup> through the external use of a breast prosthesis or through internal reconstructive surgery. These particular 'breast substitutes' can be interpreted as attempts to recover the 'natural' breast. It is to an analysis of these issues that I now turn.

## Mastectomy and Prosthesis

...the scar, the missing piece, the place where death kissed her lightly, a preliminary kiss.

-Margaret Atwood<sup>10</sup>

The most traumatic form of breast surgery is the mastectomy, usually performed as a result of breast cancer. Women who have mastectomies often express ambivalent feelings about losing their breast to cancer. Dawn, a voluntary mastectomy counsellor, likes to emphasise the positive aspect of beating cancer rather than dwelling on the fact that the women have lost a breast as a result of their cancer diagnosis:

In 1977 and 1979 I had a mastectomy each year. I've never regretted having a mastectomy and I think it is much safer to do that than to just have a lump removed and risk them having another go at it... because there are a lot of people (who) have to go back later on...and have a mastectomy. So my idea would be to have a mastectomy, that is only my personal view... I don't think it is any more difficult to cope with a mastectomy than a lumpectomy... I found it difficult to accept the fact that I had cancer but the fact that it was a mastectomy, I was very glad to get rid of the breasts so that at least hopefully it had all gone (Dawn 28/10/92).

A general lack of information about mastectomy, and the cultural silence surrounding it, has meant that a lot of women have no idea what to expect when faced with the prospect of having a mastectomy:

It is amazing the people who don't know what they (the surgeons) do when a person has a mastectomy...you just have a thin line, just an ordinary scar either like that [/] or across that way [-], but some people can't imagine anything like that, they are thinking you've had a breast removed so you've got a huge raw area where they've virtually cut it off (Dawn 28/10/92).

Pamela, a former breast cancer patient, also commented on having trouble finding helpful and up to date information on Mastectomy and breast surgery<sup>11</sup>:

<sup>9</sup> See, Smith (1990: 185)

<sup>10</sup> Atwood, Margaret (1981: 240) *Bodily Harm*.

<sup>11</sup> An exception to this trend is *Breast Awareness - How to detect and deal with breast lumps and other breast problems*. The book has good, accurate and simple information on breast surgery, [in particular mastectomy and reconstruction], by Cath Cirket (1992) Thorsons, Harper Collins; London.

I wasn't given anything to read, as soon as I knew I was going to have a mastectomy...I got some books out from the library, but they were very old and there was not a lot around, I looked in shops even to buy them but there was not very much that I thought was particularly helpful (Pamela 25/10/93).

Both Pamela and Dawn recognise the importance of providing information to women who are about to have breast surgery. Pamela actively sought information from books and from talking to women who had been through similar experiences to herself. Sharing information and experiences was common to all of the women I interviewed who had undergone breast surgery. Dawn's advice to women who are about to undergo a mastectomy is based on her personal experiences of breast cancer. Through encouraging women to consider mastectomy over lumpectomy she prioritizes safety over the aesthetic appearance of the breast. Dawn downplayed the importance of the breast as the symbol femininity, but used a prosthesis to construct an illusion of a 'natural' breast.

Mastectomy prompts women to become engaged in discourses and practices which involve the use of an artificial breast prosthesis to achieve an approximation of their original breast shape. Following mastectomies most women are encouraged to use an artificial substitute for their breast in order to appear 'normal' and not disrupt conventional expectations about women's body shape. The Breast Cancer Support Services (BCSS) booklet, available from the Cancer Society, provides the following advice for women who decide to use a breast prosthesis following their mastectomy:

For a normal confident appearance, the breast form must have the same shape as your natural breast and remain firmly in position. Your bras and naturally your prosthesis, must fit well to eliminate rubbing or chaffing...Silicone is used by manufacturers in the making of breast forms... A newly developed type using silicone compound feels just like real breast tissue and always resumes its natural shape. It may be worn with or without a pocket in any properly fitted bra (BCSS 5-6).

This emphasis on restoration of 'normal' appearance in women who have mastectomies is also encouraged in advice about health and fitness following their mastectomy:

Swimming is an excellent post-mastectomy therapy. Fit a breastform in your swimsuit, or alternatively cut a foam plastic sponge to the desired shape and set it in (BCSS 7).

In Chapter One<sup>12</sup> I suggested that the female breast was a sign, symbol and an icon of femininity, sexuality and womanhood. The implicit connection of femininity to the breast can be read into discourses which emphasise the need to reconstruct and maintain a normal appearance as an important part of rehabilitation following mastectomy. However, some women continue to feel that a prosthesis is uncomfortable and 'artificial'. For example, this emphasis on restoration of normal appearance in women who have mastectomies was disrupted by one woman I interviewed who had a breast reconstruction after her mastectomy. Pamela said she might not have had a reconstruction if both her breasts had been removed and her body had not been asymmetrical:

I hated the prosthesis,...it might not have been so bad if I had both of them off and I was balanced, but only having one (breast) you couldn't go around with nothing on the other side (Pamela 25/10/93).

Although Pamela suggested that the artificial breast prosthesis looked and felt like a real breast when it was underneath her bra, she felt it was more of a nuisance in her day-to-day life. Pamela's impatience with her prosthesis probably reflects the fact that she had decided to have a breast reconstruction while she was still in hospital recovering from her mastectomy. Pamela wore a silicone prosthesis for only three months while waiting for the scar tissue from her mastectomy to heal so she could proceed with her reconstruction:

...at first it (the prosthesis) was just a padded thing, but once I'd healed I had a proper... silicone thing... I mean it was very realistic and all the rest of it but it never felt real, and when it got hot you could feel (...), you perspired under it and I could hear it flapping. I used to think Oh... (god)... used to make me shudder. It used to be always falling out when I was in the garden and things because I was naughty and didn't make a proper pocket for it in my bra like I should (Pamela 25/10/93).

## **Breast Reconstruction**

A breast reconstruction is usually performed following a mastectomy or when the breast has been damaged, for example, in an accident. There are several different surgical procedures available to reconstruct part of the breast lost or to reconstruct fully the total breast. A reconstruction can be performed directly following the mastectomy or following the surgery and any other additional treatment (BCSS, 8). Following her mastectomy, Pamela was approached by two health professionals and asked if she would consider having a breast reconstruction. Until then Pamela had not realised a reconstruction could be an

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<sup>12</sup> See Section 1.2.

option for her. However, once this option was suggested to her, she knew that was what she wanted:

Pamela: When I was in hospital they were talking about it, telling me about it. I don't think I knew anything about it before hand, but once I knew I decided that I wanted to have one. In fact if I couldn't have one I wouldn't have known anything about it...the advice I got from the cancer nurse who came out and saw me, she thought it was a good idea.

SP: So the nurse brought up the reconstruction?

Pamela: I think it might have been the surgeon and she talked about it as well (25/10/93).

The methods used can involve either the use of an artificial breast implant or the patient's own tissue depending on the body type of the individual. For example, the tissue used in Pamela's reconstruction was taken from her stomach, as opposed to her back, because more tissue was available there:

Pamela: I did know they could take it from the back or the stomach.

SP: So did you go through the process of making a choice or did the surgeon make that choice for you?

Pamela: Well I have not got much fat on my back but I've got plenty on my stomach.

SP: So that really dictated it?

Pamela: I suppose so, yes... I was quite happy to have the stomach (done), I thought well I may as well have a bonus while I'm having it.

SP: So it reduced the size of your stomach?

Pamela: Oh yes, yes (25/10/93).

Although Pamela was very happy with her reconstruction she said the breast reconstruction was a difficult operation to go through:

When I had the mastectomy, I was just amazed... I remember saying to the surgeon I can't believe it, it doesn't hurt... that one was nothing but this one (the reconstruction) was, I mean this was much more painful (Pamela 25/10/93).

Despite the pain and discomfort Pamela thought the results were worth it in the end:

I'm really pleased you know. They could have taken a bit more fat that is all (laugh)... [but] that's just vanity (Pamela 25/10/93).

Dawn thought the 'natural' reason why some women would choose to have a reconstruction following mastectomy would be because they were conscious of how they looked or because they felt they had 'lost' their femininity. In fact it is expected that women should experience a sense of loss or grief following the removal of a breast. Implicitly these discourses link women's self esteem to physical appearance and to breasts as an icon of femininity:



There aren't many who have reconstructions, I couldn't tell you what the figures are, there are a few people that think they have lost their femininity...through having a mastectomy...a person that wanted it done, of course, would naturally want it done because they were conscious of how they looked...the only reason I could think of anyone even considering having it (a reconstruction) done would be perhaps a very young person, who was very conscious of her figure and perhaps the husband wasn't coping well... (Dawn 24/10/92).

Dawn suggested that young women who are figure conscious or have partners who cannot cope would be more likely to seek a reconstruction. In contrast to Dawn, Pamela (51) discusses how her husband was supportive of her decision to have a breast reconstruction. She explains how she felt about her body following her mastectomy, and suggests these feelings were secondary to her need to feel 'normal' so she could keep up with her colleagues at work:

SP: Was your husband supportive (about your decision to have a reconstruction).

Pamela: Oh yes, he wanted me to, and for nice reasons,...because he thought it was better for me. I know I probably shouldn't be having to do these things but you really feel freakish when you are odd, you know, you've only got one side - flat and one side sticking out - you do. Only I didn't feel it from the point of view of being a woman and sex and all that sort of thing, but just from being a person and going to work and all the rest of it. I mean plus the fact that where I work there are a lot of young people, and you have got to keep up with them that is another pressure on me obviously. I...didn't want anything else making me not feel that I could keep up and all the rest of it. I don't know if it was all the wrong reasons but that is the way I felt (25/10/93).

Both Dawn and Pamela employ contradictory ideas about the natural and artificial in talking about breast prostheses and reconstruction. In the following extract Dawn emphasizes how a prosthesis looks just as good as a breast reconstruction when you have your clothes on, but then goes on to describe how the illusion of a natural breast, created through either a prosthesis or a reconstruction, is destroyed once a woman takes her clothes off:

...but even if you have a breast reconstruction there is no way it is ever going to look natural when you have got your clothes off. And if you've got a good prosthesis, nobody would know whether you had breast reconstruction or you were wearing a prosthesis, so what is the point, and you can go swimming, there is nothing that you can't do, without you know, if you have not had a breast reconstruction (Dawn 28/10/92).

In the following extract, Pamela also acknowledges how a reconstruction is different to her original breast. Pamela's attempts to recreate a 'natural' breast through her reconstruction is more successful in terms of appearance than sensuality:

Pamela: ...you don't get the same feelings out of the breast reconstruction as you ever did (with) the original, so you are not really the same, but you still feel better about yourself and you don't have to worry about that jolly prosthesis which I hated.

SP: You don't see yourself using cosmetic surgery to enhance like other women might?

Pamela: No, to approximate what it was before, yes I didn't want to be any different (25/10/93).

Several months after her breast reconstruction, Pamela had a second operation to recreate a nipple. Pamela had both the breast and the nipple reconstructed because she did not want to be different or noticed as a result of her mastectomy:

SP: Did your reconstruction involve creating a nipple?

Pamela: They do that later. I had a second operation for that.

SP: What did they do?

Pamela: ...they used the breast reconstruction to make the [nipple]...but to make the areola...they took a piece out in between...

SP: The labia you mean?

Pamela: No high up [points to the upper thigh].

SP: Oh the thigh yes, when I talked to the surgeon he said they can take it from the thigh.

Pamela: Yes and it is not quite as dark as the other side but it is not too bad, I really don't know if that was so necessary. To have that done really, but I'm quite pleased with it. Because you can go without a bra and people don't notice it...(25/10/93).

In suggesting that cosmetic surgery is 'just vanity' and questioning whether her cosmetic surgery was 'necessary' or 'for the wrong reasons', Pamela problematises her decision to have a breast reconstruction. Pamela did not see her breast reconstruction as simply cosmetic, but as restoring her appearance to what it was before her mastectomy. Pamela's advocacy of breast reconstruction, as restoration of 'normal' appearance, is in contrast to the opinion of the majority of medical professionals who see reconstruction as a purely cosmetic procedure. For example, doctors Marcia Angell (1992) and David Kessler (1992) MD, for the FDA have suggested that 'since mastectomy can be and usually is performed without reconstruction', the major benefit of breast reconstruction is cosmetic (Angell 1992: 1095).

## Breast Reduction

One of the least controversial forms of breast surgery is breast reduction. It is the form of breast surgery commented on most favourably in the mass media. Articles on breast reduction are presented positively, often accompanied by before and after pictures. For example a magazine article titled, 'When less is more...down-sizing when breast surgery changes lives' suggests:

'Bigger-than average breasts cause women problems in three major areas. Firstly there is the psychological side...Then there's the comfort and convenience angle...There are also a number of medical problems...' (*More*, 07/93).

Discourses surrounding breast reduction emphasise health, comfort, convenience and aesthetic appearance. They are similar to Victorian arguments against tight-lacing which were based on considerations of health, comfort and beauty. Ironically the arguments against construction of the female form through tight-lacing are echoed in discourses advocating recreating a 'normal' (feminine?) shape via breast reduction. The following extract from a newspaper article titled, 'Breast reduction worth more than the money' discusses the sorts of problems encountered by women who have 'big low-hanging breasts':

'Before her breast reduction Karen took a size D or DD bra cup...Buying bras was a problem...She also had back and shoulder pain and chafing and sweating under her breasts. She worried about how she'd look and cope in ten years' time when her breasts dropped even more...' (*The Press*, 04/06/91).

The discourses surrounding breast reduction employed by the plastic surgeons and media emphasize the negative health and psychological consequences of large breasts, including back problems, poor posture and low self esteem. They stress the positive life changes that can result from a breast reduction, for example:

'Now after having about a kilogramme removed from each breast Carol is free of back pain. She has also been swimming again and can wear a normal bra. "I can fold my arms too", she exclaims delightedly. "My only regret is that I didn't have it done years ago"' (*More* 07/93).

'Now I'm just normal like everyone else' - Robin [46], (*More* 07/93).

'I thought the operation would make me happier - and it did' - Monica [31], (*More* 07/93).

'Afterwards I feel so much freer! It's definitely been worth it' - Lisa [16], (*More* 07/93).

The women who have breast reductions also appear to emphasize the need for a breast reduction in terms of their health and psychological well-being. In this sense they view their cosmetic surgery procedures as being more legitimate and necessary than other forms of cosmetic surgery. One woman I interviewed, whose original breast size required a size 44 bra with a double E cup, had her nipples repositioned upwards by ten centimetres during her breast reduction:

I had a breast reduction in 1988, I'd been thinking about having a breast reduction since I was eighteen...sometimes I thought 'silly idea'...I had saved up a lot of money to go overseas, and then I bumped into this woman who I knew had just had a breast reduction, and she was just raving about how wonderful it was, and I thought: 'God I've just got to have one', because I got to the stage where my breasts were really sore all the time, and my back was quite sore from carrying them around and I was just sick to death of them,...talking to this woman really started me thinking about it (Lucy 21/08/91).

The majority of discourses surrounding breast reduction downplay the aesthetic benefits of the operation, stressing instead the health, comfort, convenience and psychological benefits that result from the surgery. However, breast reduction is also a form of cosmetic surgery, as the following magazine extracts illustrate:

'Breast reduction not only reduces the size of the breasts but lifts them back to a more natural position' (*The Australian Women's Weekly*, 02/93).

'It's about being normal'...'You don't want to look fantastic you just want to look normal' - Dr. Carry Mellow, Plastic Surgeon (*More* 07/93).

Breast reduction is not only about approximating to a 'normal' breast size, magazine articles suggest it is also about reconstructing a 'more natural' or aesthetically pleasing breast. The above discourses emphasize the need to 'look normal' and 'natural'. Lucy also played down the lifestyle changes resulting from a breast reconstruction and emphasized the need to feel good about herself and her breasts:

Having a breast reduction and the expectations it creates about lifestyle is a bit like those ads that say once you've used tampax you can swim, you really have to be motivated to make those changes...I started doing aerobic classes after I had my breast reduction and there was quite a lot of difference in how I was able to move my body. The major difference though is about how I feel about my body, but also how other people see it, so that I can actually feel OK about my breasts (Lucy 21/08/91).

For Lucy a major reason for having a breast reduction was not the comments and taunting many large breasted women receive from men and women in their day to day lives, but the obvious and overt unspoken fascination men had with her breasts:

I was probably about seventeen when I became aware of my breasts, boys made comments, but what I used to find particularly difficult was working with the public,...men would come up wanting help, and what I would find was that men would look at my eyes look at my breasts and stay fixated for the entire conversation, at the time I never really had the idea of staring at their penis which is what I'd do now. So I found that very offensive and sometimes I would say to them, 'Excuse me, could you look me in the face while you're talking to me'. Sometimes I would be just too

embarrassed to do that. I found once I had my breast reduction and was doing exactly the same work, they would just be looking me in the eye, looking me in the breast, looking me in the eye, the way that it is usually done...so I noticed that, but it wasn't so much the comments as unspoken fascination... (Lucy 21/08/91).

Lucy comments on the sexualisation of breasts within our culture, and describes how uncomfortable she felt when exposed to this gaze. Lucy had a reduction because she felt she received too much attention that focused on her breasts, in contrast to other women who enhance their breast size to achieve the opposite effect. Lucy's breast surgery, while a form of cosmetic surgery, can also be interpreted as a covert form of rebellion against the objectification of the female breast in our culture. In addition she had her reduction not only to approximate to an average breast size, but also as a form of security (the security of anonymity and normality) and empowerment (the ability to 'get on with her life'). The way Lucy talks about her breasts and her breast reduction provides a good example of how women who use cosmetic surgery to alter the size and shape of their breasts, access multiple reasons for their decision to have cosmetic surgery, playing around with the discourses on cosmetic surgery available to them within popular culture. However, Lucy was also quite emphatic about distancing her decision to have a breast reduction from the widespread cultural belief that women who have cosmetic surgery have a distorted body image:

Lucy: ...at the time of deciding it (my breast reduction) I was quite open about it, and it embarrassed men and blew a lot of the women away, because I wasn't hiding it, a lot of people do....

SP: The secrecy surrounding women who have breast reductions seems to be quite common.

Lucy: If it's about changing your body because of a distorted body image, or not liking your body, then who would actually say well I feel so bad about my body I'm going to have some surgery on it, that's why people were so surprised because they thought I was doing that because I didn't like my body, because that is their own fat phobia (21/08/91).

In Chapter Two<sup>13</sup> I discussed how feminist discourses construct cosmetic surgery as being an anti-feminist practice. Lucy's openness about her breast reduction lead to a comment about her cosmetic surgery being incompatible with her feminism:

...reactions from other people were interesting, like one woman I worked with...said: How can you as a feminist have a breast reduction? And I had never thought of it before as anti-feminist, because I wasn't doing it because I didn't like my body, I was

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<sup>13</sup> See Sections 2.6 and 2.7.

doing it because my body could no-longer tolerate the weight of my breasts... (Lucy 21/08/91).

In the above quotes Lucy problematises the discourses and practices surrounding cosmetic surgery and she reflects critically on her decision to alter the size of her breasts. In doing so she challenges hegemonic (feminist) assumptions about women who have cosmetic surgery. Women who opt for breast augmentation also problematise and defend their decision to alter the size of their breasts. The following section considers how the experiences of two women who had breast augmentation in 1993 disrupt feminist assumptions about women who have this form of cosmetic surgery.

### **Breast Augmentation**

Most feminists who write about feminine embodiment take a uniformly negative view of breast augmentation. Within this literature silicone implants are 'breasts surgically stuffed with plastic' (Bordo, 1993c: 189), seen as 'frivolous and unnecessary, like diamonds or furs' (Young, 1990: 202), and considered women's antidote to the attainment of masculine power (Wolf, 1991: 212 & 241). Morgan and Faludi emphasize the negative outcomes of breast augmentation including hardening, removal and increased risks of cancer (Morgan, 1991: 23; Faludi, 1991: 251-253). Implicitly these discourses suggest women who opt for breast augmentation are 'cultural dupes' compelled by social forces beyond their control or comprehension.

Kathy Davis suggests feminist research into cosmetic surgery needs to reinstate women as 'active and knowledgeable actors within the context of structured limitations' (Davis, 1991: 33). Women who have breast augmentations make informed choices within the context of particular structural constraints. They are often aware of these constraints and the potential negative consequences of their cosmetic surgery decisions. However, this knowledge is set in the context of the pleasures and possibilities that breast augmentation also offers.

For many women breast surgery will be an ambivalent experience. Therefore understanding why women opt for breast augmentation necessarily involves recognising how the women themselves articulate their personal experiences of the constraining and enabling features of this cosmetic surgery procedure. In the following conversation Isabel [35] describes her breast enlargement in terms of personal and physical transformation. She emphasizes the lifestyle

benefits while at the same time acknowledging how her enlargement can be viewed as conforming to male expectations about breast size:

Having the implants changed my whole life, I feel more confident, and much happier with the shape... I think men do treat women differently, initially men do see that you have got breasts and they do find it more attractive. It can be shallow, and I suppose it (breast augmentation) reinforces that (Isabel 21/04/94).

Sarah [32], like Isabel, suggests that one of the major benefits of her breast enlargement has been a dramatic increase in self confidence. She explains that her silicone breast implants have not prevented her from continuing to have an active lifestyle:

I can go in the water, exercise, no problem. I have heaps more confidence and I feel a different person. It is a confidence booster, you come across more confident, and the way people react to you makes you confident (Sarah 21/04/94).

Sarah talks about how her breast augmentation has enhanced her self esteem; she now describes herself as a 'different person'. Isabel has had her breast size increased from an A cup to a large B/small C. In the following conversation she talks about how her breast augmentation prompted her to buy new clothes that would complement her new shape and personality:

Some people wouldn't know I've had an enlargement, it is only in a swimsuit or bodysuit that I am noticeably larger. The major difference is in the way you present yourself. I had implants because I wanted to look sexy, I thought my legs were nice and I wore off the shoulder tops, but I would never dream of clothes with cleavage because there wasn't any. It is like getting your hair cut in a funky style, you wear clothes to suit, if you have a more conventional style you wear conservative clothes to match (Isabel, 21/04/94).

Through breast augmentation and clothing, Isabel was able to actively craft a new identity for herself - a process she likened to changing your image from 'conservative' to 'funky' through hair styling. Isabel spent part of her divorce settlement on cosmetic surgery. She uses breast augmentation and eye-lid surgery, not only to raise her self-esteem and confidence, but also to repackage herself in relation to an image of femininity she thinks will be attractive to a potential partner.

Sarah's large 240cc implants increased her bust size from a 34A to a 36D cup<sup>14</sup>. She is a sales representative for a medical company that sells breast implants<sup>15</sup>.

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<sup>14</sup> In the following conversation Sarah talks about different breast implant sizes:

Sarah paid for the operation herself after she received an offer of a free set of implants from her employer. Unlike Isabel, Sarah does not wear clothes to accentuate her new shape:

After I had implants I brought a sexy bra but I don't wear anything with cleavage. I like the shape, and sometimes I wear a bodysuit, which I never would have worn before to make me feel good. Before the implants I had long curly blonde hair and because of my appearance if I'd shown off cleavage it would have come across tarty. After the implants I had my hair cut short and dyed dark, so I think I look more professional (Sarah 21/04/94).

Sarah provides a strong statement of resistance to understandings often attached to women who have breast enhancements. She describes how she strategically uses appearance to craft a 'professional' image while enhancing her breasts - not necessarily for display - but to feel good about herself. Sarah simultaneously engages with discourses that link sexuality to breast size and seeks to resist them through changes to her hair. Sarah wants to do professionalism and sexuality; she talks about how she does 'femininity' and 'sexuality' differently in different social contexts. Her experience of breast augmentation means she is able to be a more effective sales representative. Sarah is an asset to her company; a tangible demonstration of confidence in their product. Both Sarah and Isabel's breast augmentations can be set in the context of the economic opportunities that might result from this cosmetic surgery procedure. Isabel's breast enlargement is a way for her to access the potential status and economic security that might result from a new partner, while Sarah's job security is enhanced because her product knowledge is superior to those of her colleagues.

Both Sarah and Isabel talk about how body shape is vitally important to their sense of self. Breast augmentation is most visibly a way to remould the body as object. In the following conversation, Isabel describes how her saline implants 'balanced out' her figure and gave her a 'more aesthetically pleasing' body shape:

The implants balance out my figure. I have a classic pear shape, small waist, big hips, so now I have got a much more aesthetically pleasing figure. I was really pleased with the result (Isabel 21/04/94).

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I had a 240cc implant. That is quite a large implant, 180cc is the average but some women have 650cc implants. So now I've got a 36D, I had a lot of spare tissue so it looks really natural (Sarah 24/04/94).

<sup>15</sup> Sarah obtained this position through her interest in breast augmentation. She met a sales representative for this company socially, and talked to him about her desire for a breast augmentation, this contact eventually lead to her current a position within the company.



Davis suggests feminist analyses of cosmetic surgery only consider the transformation of the body as object never as self (Davis, 1991:29). They concentrate on the final signifying product rather than on the material processes of cultural production (of the body). Sarah and Isabel actively recraft their identities through hair, clothes and breast augmentation. Both Isabel and Sarah talk about how hair symbolically represents social identity (funky/professional). Both women consider that changing the shape of their breasts to be in some ways similar to changing your hair through colour and style. Changing her breasts means that Isabel can pursue a more sexual image - especially through her choice of clothing. For Sarah feeling sexual through her breast enhancement means that she does not have to use hair as a signal that she is sexual. Sarah suggests she can now choose a professional, de-sexualized hair style because she 'knows' she has a more sexual and conventionally feminine body.

Cosmetic surgery is not an option taken lightly by women; it is expensive<sup>16</sup> and potentially dangerous, and often women have to justify their decision to have cosmetic surgery to their families and friends. In the following conversation Sarah talks about her mother's reaction to her decision to have silicone breast implants and describes the process of proving to her mother that her decision was safe and rational:

My mother had a canary when she found out I wanted implants. I took her all the information to read and showed her a video, so she accepted it once she had more information (Sarah 21/04/94).

Isabel was quite open about her decision to have a breast augmentation. She found that her friends' reactions were mostly negative:

I didn't keep it a secret, I told my friends, the majority thought it was not a really good idea because of all the publicity (about the risks). Two of my friends were still breast feeding so they were quite chesty. When they stopped breast feeding they no longer liked their shape, so then they were more understanding and supportive. Now they want breasts like mine. After the enlargement everyone really has been positive (Isabel 21/04/94).

Isabel chose to proceed with her decision to have breast implants despite an initial lack of understanding and support from her friends. Sarah presents herself as actively choosing to have cosmetic surgery<sup>17</sup>. Her description of the

<sup>16</sup> According to Sarah, the breast implant operation costs approximately five thousand dollars.

<sup>17</sup> Sarah had an abdominoplasty (tummy tuck) at the same time as her breast enlargement. She was looking into the possibility of having liposuction at the time I interviewed her.

process through which she decided to have a breast augmentation emphasizes her sense of agency:

I think they are wonderful, I have Silicone-gel implants. I read up on all the options and chose gel, because it was the best for what I wanted. Because with saline ones some women say they can feel the valve under the skin and I didn't want that (Sarah 21/04/94).

Sarah 'read up' on the options and talked to other women, she also used a video on breast augmentation as part of her decision-making process. Sarah chose to have silicone-gel breast implants because she perceived them to be 'the best' for her as they were less obvious (more natural?) than saline implants.

Davis suggests 'the decision to undergo cosmetic surgery is a problematic one, requiring ongoing deliberation and justification' (Davis, 1991: 32) In the following conversation Isabel talks about the way breast enlargement conforms to expectations of femininity that are defined by men:

I'd say I was a victim of that, but if it makes me feel better then that is my business...I'm certainly not a stupid person, I feel in a way I'm getting back what I had before I had children and breast-fed. Men are not subject to the variations of women's bodies so its easier for them. I go to the gym, but there was no pressure on me to have implants (Isabel 21/04/94).

Isabel considers that men set high standards for women because they experience very little variation in their own bodies, whereas women have to cope with changes in their bodies associated with menstruation, pregnancy and menopause. Isabel defends her decision to use cosmetic surgery as 'my business'. Instead of conforming to an unobtainable ideal of femininity she suggests she was attempting to recover her original breast size. For Isabel cosmetic surgery is a deeply contradictory and ambivalent experience. As her comments below indicate, her enjoyment is constantly tempered by reflections on the external factors that contributed to her eventual decision to have cosmetic surgery:

It would be better if men's expectations were less. It is a shame that we feel that way about ourselves, but the way it has improved my life is just fantastic. I had my eyes done at the same time, I would have got that done on its own, it's minor surgery but it makes a huge difference to the way I feel about myself...It is just great, eyelids are two grand fifteen hundred dollars for a lifetime, it is such a good investment, so little money (Isabel 21/04/94).

Isabel suggests women would not feel compelled to have cosmetic surgery if they did not encounter men's expectations about the 'ideal' female body. In

contrast she describes her cosmetic surgery as 'fantastic' and 'a good investment'. When asked what pleasures she now experienced as a result of her breast augmentation, Isabel said she liked the personal and aesthetic differences that resulted from her breast surgery:

...clothes shopping is much better, I feel more sexual (Isabel 21/04/94).

Before her breast augmentation Isabel was embarrassed to get undressed in the public changing rooms at the gym. The gaze of other women was also important to her sense of self. This disrupts assumptions that women who have breast implants are seeking to construct themselves only for an imagined male gaze. For Isabel the female gaze was also an important factor influencing her decision to have a breast enlargement:

I did it not only for me but for other women. When I went into the changing rooms at the gym I wouldn't get undressed in front of the other women. At the time I decided to have implants I was toned, a stone lighter than I am now and in really good shape, I had nice legs and looked good in bike shorts, I went to the beach and was I brown! I remember at the time a girlfriend saying to me you are going to have the perfect figure when you have it done (Isabel 21/04/94).

The visual and verbal reinforcement of other women was important to Isabel; she was particularly pleased with the above comment from her girlfriend. Isabel indicates that she is working on her body in a variety of different ways; she ensures that her body is toned, exercised, slim the next step is to enhance her shape through breast augmentation.

For Isabel and Sarah cosmetic surgery is obviously a source of pleasure. While their cosmetic surgery experiences are fairly recent, one woman I interviewed, who had her breast augmentation in the late 1970s, also describes the enjoyment she felt following her augmentation. Helen<sup>18</sup> [38] had silicone-gel implants when she was 25. For the first twelve years they were an unproblematic pleasure, but then she experienced a range of health problems. Finally they were removed. Despite her later problems with the implants, Helen remembers vividly her delight with her breasts after augmentation surgery:

After the surgery I was really thrilled with the result. I wasn't overly huge, but compared to the size I used to be, I felt enormous, just like Dolly Parton. I was now a C cup, and I must admit I did have fun with them for twelve years (Helen, 07/06/93).

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<sup>18</sup> See 'Helen's Story' at the beginning of Chapter Five.

Like Sarah and Isabel, Helen's initial experience of breast augmentation is best described as one of 'exhilaration' (Davis, 1991: 24). Helen was 'really thrilled', while Sarah thought her implants were 'wonderful' and Isabel said she was 'really pleased' with the results of her surgery. Feminist analyses of cosmetic surgery do not allow for consideration of the pleasures women might experience or express as a result of this practice (Davis, 1991: 29). The women interviewed talked about transforming the body as a source of pleasure. These pleasures included (re)crafting identity through exercise, clothes shopping, going to the hairdresser and breast augmentation.

The women interviewed actively chose to have their respective breast augmentations. They also problematised their decisions to have cosmetic surgery, often recognising the factors which shaped these decisions and the contexts in which they were made. Davis suggests:

In order to understand how cosmetic surgery might be actively chosen within a context of limited options, reconceptualisations of both the notions of structural constraint and individual choice are in order (Davis, 1991: 33).

This analysis necessarily involves actually talking to women who have cosmetic surgery and taking what they have to say seriously. Following her breast augmentation Isabel described her new figure as 'aesthetically pleasing' and 'perfect'; as a result she was 'happier with the shape'. Sarah also said she liked the shape of her 'new' breasts.

The women interviewed had their breast augmentations not only to alter the physical shape of their breasts, but they also described their breast enlargement in terms of lifestyle and personality changes. Isabel said her implants 'changed' and 'improved' her life, while Sarah suggested her implants enabled her to feel she was 'a different person'. Both women describe their breast augmentations as part of a process through which they could recraft their identities and improve their self esteem. Isabel wanted to be 'more sexual' while Sarah thought the combination of her new hairdo, and her breasts made her look 'more professional'. While Isabel described her breast enlargement as 'fantastic' and 'more attractive' she also acknowledged that men's idealised versions of women's bodies were 'a shame', and 'shallow'. She acknowledged she was a 'victim' of cultural expectations of women, but also defended her actions by stating she was 'certainly not a stupid person', and that her breast augmentation was 'my business'.

### 3.4 TAKING AGENCY SERIOUSLY

I have argued that the women I interviewed who had had breast surgery engaged problematically with the discourses and practices of cosmetic surgery. Their experiences of these practices can be read as containing contradictory elements which could be interpreted as subordination, conformity, security, and empowerment. Cosmetic surgery, often portrayed within feminist discourses and the mass media as an extreme means of approximating the idealised images of femininity within Western culture, can also be analysed as a way of transforming body shape and/or appearance by choosing to use a variety of available technologies, including cosmetic surgery, dieting, make-up, hairstyles, lingerie (bras and corsets), and exercise programmes.

The contradiction and ambiguity surrounding aesthetic transformation, and the pleasures it engenders, has some obvious connections with what Foucault identifies as discourses and practices of resistance and refusal (1978: 101). Rather than focusing exclusively on the terrain of control in cultural production, analyses of cosmetic surgery can investigate the ways in which resistance and refusal is enacted through cosmetic surgery. This involves analysing discursive texts - photographs, magazines, television programmes - and the meanings, pleasures and experiences of women who have cosmetic surgery. According to Laurie Schulze:

The focus of critical inquiry shifts from the operations of hegemony in texts to the ways in which individuals actively make meanings and take pleasures from texts in ways that may resist or evade domination, and in ways that help to make sense of aspects of their social experience (Schulze, 1990: 66-67).

Articles in magazines and newspapers about cosmetic surgery usually offer dominant readings of this practice. When alternative or oppositional discourses are acknowledged they are usually presented in opposition to these preferred readings<sup>19</sup>. These textually mediated discourses construct a female subjectivity that reflects dominant understandings of breast surgery as a social practice tied to hegemonic relations of femininity. Throughout my research into cosmetic surgery I have been unable to find a single written text, academic or otherwise, which suggests cosmetic surgery can be seen and/or used as an act of resistance or refusal of conventional cultural constructions of the female body<sup>20</sup>. Yet

<sup>19</sup> See Chapter One Section 1.2 for an analysis of the way cosmetic surgery is presented in the New Zealand print media. Appendix two also lists, by date, some of the cosmetic surgery articles that appeared in the New Zealand print media between May 1991 and July 1994.

<sup>20</sup> Davis' (1991) analysis of cosmetic surgery is framed around issues of choice and rights; her discussion centres on problems of agency, normalcy and justice (p. 33). While Davis is resistant to

clearly some women are incorporating discourses of resistance into their accounts of their experiences as clients of cosmetic surgery. For example, Lucy explained how her breast reduction turned out to be a successful strategy of resistance against the sexualisation and objectification of her breasts within patriarchal culture. Sarah's description of how she reworked her appearance, to present a 'more professional' image following her breast augmentation, resists a stereotypical femininity which is often attached to women who have this form of cosmetic surgery.

According to Schulze, resistance can also be seen as working through the physicality of the body, 'scandalizing ideology through openness, fragmentation, nonsense, surface, heterogeneity and fun' (Schulze, 1990: 67). In talking about her breast reduction Lucy's openness about her cosmetic surgery disrupted accepted conventions of social behaviour surrounding women's engagement in the practices of cosmetic surgery. Underlying the discourses and practices of breast augmentation and reconstruction are disruptive ideas about constructing an active female sexuality and taking pleasure in looking sexual. Sarah (32) had an enlargement to 'look sexy', Isabel (35) said her implants made her 'feel more sexual', and Helen's (37) breast enlargement enabled her to 'have fun' with her breasts. Pamela (51) discussed the importance of her breast reconstruction in relation to her sexuality, disrupting accepted social conventions surrounding older women and sexuality. Finally, by virtue of their participation in this research, all of the women who spoke to me about breast surgery disrupted the silences surrounding women's subjective experience of their breasts and their breast surgery.

The women I interviewed also talked about their breast surgery in terms of transformation and possibility. Both Pamela and Lucy justified their decisions to have breast surgery in terms of the opportunities they felt their surgery provided. Lucy had a breast reduction, not only to 'feel OK' about her breasts, but also so she would be able to 'get on with her life'. Pamela indicated that one of her reasons for having a breast reconstruction was so she would be able to 'keep up' with younger colleagues at work. Sarah described her breast enlargement as a 'confidence booster', and her new breast shape as 'wonderful', while Isabel thought her cosmetic surgery was 'a good investment'.

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the 'cultural dupe' approach to cosmetic surgery, she does not use discourses of resistance, nor does she address the issue of resistance specifically, in her analysis preferring instead to 'do resistance' through constructing cosmetic surgery as a form of empowerment for women.

In Chapter Two<sup>21</sup> I argued that feminist writing on the breast has tended to ignore how women construct and experience their breasts. Instead feminist analysis tends to concentrate on either breast feeding (see Palmer, 1988; Vares, 1992; Blum, 1993) or the objectification of the breast within patriarchal culture (see Young, 1990b). Feminists have tended to construct cosmetic breast surgery as a modern example of women's compliance with idealised versions of women's bodies, and therefore a symbol of women's oppression. I have already suggested that this analysis is too simplistic.

In this chapter, I have attempted to offer a more complex analysis of cosmetic surgery which involves paying attention to the often contradictory discourses of women who have had breast surgery. Feminist critiques of cosmetic surgery and breast augmentation in particular tend to focus on texts in the print media or television images rather than the 'talk' of those who participate in these social practices - either as clients or as practitioners. While my interviews with clients have not been extensive, they do indicate that some women talk about cosmetic surgery in ways that are simultaneously ambivalent, contradictory and pleasurable. According to Angela McRobbie, feminist readings of popular culture that concentrate in this way on the final signifying product<sup>22</sup> (the magazine, the advertisement, the corseted or sculptured body), miss important dimensions of cultural production that lie 'outside the sphere of textuality' (McRobbie, 1993: 414-415). For McRobbie, a new emphasis on subjectivity and process has the potential to develop more open-ended readings of changes in the (re)construction of femininity (McRobbie, 1993: 415). My conversations with women who have had cosmetic surgery were directed at challenging the exclusive focus on cultural texts which is evident in much feminist writing about plastic and cosmetic surgery.

### 3.5 SUMMARY

The talk of women who engage in the discourses and practices of cosmetic surgery often incorporate resistant or critical discourses about cosmetic surgery that challenge understandings of clients as cultural dupes. For example, the women interviewed sometimes used their experiences of cosmetic surgery to critique cosmetic surgery as a social practice. The oppression model is unable to explain why the women interviewed acknowledged some of the external

<sup>21</sup> See Sections 2.6 and 2.7.

<sup>22</sup> McRobbie compares examples of subcultural styles (the punk, the mod, the hippie etc.) to changing modes of femininity (1993: pp. 408, 410-412).

social forces in which their cosmetic surgery decisions were embedded. I have argued that instead of seeing cosmetic surgery as a domain of control and oppression, it is more important to consider different forms of breast enhancement and reconstruction as simultaneously containing elements of conformity, resistance, ambiguity, transformation and possibility. The next chapter considers how cosmetic surgery is deployed, to (re)construct the feminine body, through the discourses and practices of the plastic surgeons.



## CHAPTER FOUR

### THE CUTTING EDGE

There is no gender identity beyond the *expressions of gender*; ...identity is performatively constituted by the very "expressions" that are said to be its results<sup>1</sup>.

In many years of practice, I have examined thousands of women's breasts. Most would qualify for some plastic surgical alteration if the typical concerns *expressed by the patients* who come in for surgery were the required standard<sup>2</sup>.

#### 4.1 COSMETIC SURGERY AS A SITE OF CONTESTATION

[The plastic and cosmetic surgery industry is contested at many levels: through legislative battles over who can legally perform cosmetic surgery, malpractice and other forms of litigation, the cost of, and/or lack of, insurance coverage, market competition, safety and effectiveness issues, ethical debates and feminist challenges.] The discourses and practices of cosmetic surgery reflect a complex intersection of linguistic constructions, professional authority, as well as ideological, political and economic positionings involving such concepts as ['individual rights', 'free enterprise', 'market forces', 'institutional structures', and 'cultural ideals']. Hence, the relationship between plastic surgeons and their clients is a complex one. Its deconstruction reveals intricately woven patterns of postmodern multiplicity. It is intimately inscribed within hierarchical relations of power which simultaneously structure it as a doctor/patient and a provider/client relationship. Not unexpectedly contradictions abound. The aim of this chapter is to explore how definitions of femininity in particular come to be constructed, codified, institutionalised and mobilised within and through the discourses and practices of the agents involved in the cosmetic surgery industry.

This chapter focuses on the people involved in the shaping of women's breasts. It problematises the notion that plastic surgery is simply the reconstruction of the body according to dominant ideals of masculinity and femininity. The focus of the chapter is on the discourses and practices of cosmetic surgeons and the political economy of plastic surgery in a particular location - Christchurch, New Zealand. The discourses of plastic surgeons engaged in the internal

<sup>1</sup> Butler 1990: 25, italics my emphasis

<sup>2</sup> Jobe, 1990: 24, italics my emphasis.

reconstruction of bodies are compared to the words and practices of two surgical corsetieres involved in the use of technologies associated with the external modification of women's breasts. This analysis reflects on the way in which social practices and conventions produce, institutionalise and deploy ideals of femininity. The Foucauldian concept of 'bio-power' is considered as a mechanism through which feminine identities are crafted in relation to cultural texts and the discourses and practices of plastic surgeons, surgical corsetieres and their clients. Finally the development of cosmetic surgery technologies for the male body are also discussed; these are located in an increasing focus on an aesthetic masculine ideal.

## 4.2 DISRUPTING THE DUALISMS (AGAIN)

Cosmetic surgery is a discursive practice that simultaneously reinforces and disrupts cultural ideals of femininity. Morgan<sup>3</sup> considers the surgical recontouring of the body to be a relatively new and therefore 'unnatural' phenomenon. According to Morgan:

We have arrived at the stage of regarding ourselves as both technologically subject and object, transformable and literally creatable through biological engineering...I interpret the spectacular rise of the technology of cosmetic surgery as a form of biotechnology that fits this dialectical picture of modern technology.

Morgan (1991: 28-31) argues that the 'dialectical picture of modern technology' involves the triumph of the apparent over the real, and the technological over the natural. At the philosophical level Morgan considers that modern technologies of the body (in particular cosmetic surgery) privilege transcendence and progressive rationality over immanence and the lived reality of the body. For Morgan cosmetic surgery:

involves the exploitation and transformation of the most intimately experienced domain of immanence, the body, in the name of transcendence:...(it) is not the *real given existing woman* but her body viewed as a "primitive entity" that is seen only as potential, as a kind of raw material to be exploited in terms of appearance... (Morgan, 1991: 37, italics my emphasis).

Morgan claims scientific discourses and medical technologies subjugate, exploit and oppress the 'natural' and 'normal' body:

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<sup>3</sup> Also discussed in Chapter Two, Section 2.6 and Section 2.7.

*Natural* destiny is being supplanted by technologically grounded coercion, and the coercion is camouflaged by the language of choice, fulfillment, and liberation (Morgan, 1991: 41 italics my emphasis).

...the technological beauty imperative and the pathological inversion of the *normal* are coercing more and more women to "choose" cosmetic surgery (Morgan, 1991: 41 italics my emphasis)

Morgan believes there is a 'real given existing woman', and a 'natural' and 'normal' body; this assumption enables her to conclude that cosmetic surgery disrupts the body's 'natural' material reality. However, cosmetic surgery also deploys notions of 'the natural body' as a cultural ideal. It is my contention that it is too simplistic to assume that the debate surrounding cosmetic surgery, and its particular definition of the body as a plastic and malleable commodity, can be resolved merely by privileging the 'natural' and 'normal' over the technological and cultural. Cosmetic and aesthetic surgery fractures the boundary between 'science' and 'nature', disrupting cultural assumptions about the 'naturalness' of femininity. The debate surrounding female subjectivity, embodiment and experience, and its implications for how cosmetic surgery may be theorised, cannot be adequately resolved through exploring the 'true nature' of the body or the 'real' meaning of femininity. 'Femininity' does not exist outside of discourses and social practices, but is inscribed and made intelligible through them (Treichler 1990, 132). An analysis that considers the different ways the body has been shaped, adorned and constructed across time and space would conclude that there can be no 'natural' body waiting to be discovered outside of culture. The discourses and practices surrounding cosmetic surgery reveal the complexity in the actual deployment of the nature/culture binary opposition and the dualism it constructs between the 'natural' and the artificial, technological and cultural.

While cosmetic surgery disrupts the notion of a 'natural' femininity, it also involves a set of discourses and practices which construct and reinforce a narrow definition of femininity as the ideal. Modern definitions of femininity as a medical and social event, a natural process and a market commodity have powerful cultural backing. The development of cosmetic surgery technologies and its particular definition of certain body shapes as the ideal, has scientific, ideological, economic and social support (Treichler 1990: 120). Scientific support includes the redefinition of the body in medical terms, technological developments and the teaching of cosmetic surgery techniques. Ideological support involves the role of scientific thinking in the deployment of a professional medical authority which defines deficient or abnormal body

shapes. Economic support centres on market competition, the profitability of the cosmetic surgery industry and the potential profitability of the reconstructed body. Social support involves cultural ideas about women's bodies and what constitutes an ideal representation of femininity. In addition, cosmetic surgery is supported within popular culture, evident in discursive texts which construct it as the ultimate in self-indulgence<sup>4</sup>. For example, cosmetic surgery is often equated with wealth and is sometimes referred to as 'knifestyles of the rich and famous'<sup>5</sup>.

People involved in breast reconstruction in New Zealand reiterated some of the theoretical themes which have been summarised. Pamela, a former cosmetic surgery client, acknowledges the construction of cosmetic surgery as a luxury commodity. She felt she had to justify her decision to have cosmetic surgery; in doing so she draws together a complex arrangement of political, economic, medical, psychological and lifestyle discourses:

In New Zealand particularly and I suppose anywhere where they have got a welfare state you find it very difficult to spend that sort of money on yourself for medical reasons...So I found that difficult to justify, but then I thought: 'Well you would pay that sort of money for a car wouldn't you? So why not spend that sort of money on yourself, because of what a difference it makes to your life, your concept of yourself.' I know that it is only a concept, but it is most important to you (Pamela: 25/10/93).

The social support for cosmetic surgery is also evident among some groups of women who attach a certain social value to having a cosmetic surgeon. For instance, Naomi Wolf (1991) looks at the cosmetic surgeon as sex symbol and draws a parallel between the deployment of medical authority and pastoral power:

The cosmetic surgeon is the modern woman's divine sex symbol [*sic*], claiming for himself the worship that nineteenth-century women offered the man of God (Wolf, 1991: 95).

John Camp also suggests that there are similarities between the guild status and rituals of religion and medicine. He characterizes surgeons as 'latter-day priests' (1989: 111) and their profession as a 'priesthood'. Camp describes operating theatres as 'expensive temples of medicine' and suggests that the

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<sup>4</sup> See 'Cosmetic surgery: A new body for \$15,000', *Mode* October/November 1993. 'What cosmetic surgery can do for you. Stars do it, celebrities do it and now, ...you can do it too'. *Australian Woman's Weekly*, February 1993.

<sup>5</sup> See 'Cutting Edge' in *ES*, June 1993.

prestige, wealth and exclusive knowledge of surgeons parallels the status accorded to old testament priests (Camp, 1989: 116-117).

In Chapter Three<sup>6</sup> I suggested that viewing the body as a plastic and malleable commodity has clear conceptual links with historical discourses describing corsetry and tight-lacing. The definition of the body as a scientific and medical commodity within the aesthetic surgery industry is also reflected in the discursive practices of the cosmetic, dieting and fitness industries. The texts about anti-aging tablets and creams, exercise fashions and weight-reducing diets also claim professional legitimacy through scientific and medical discourses. The historical medicalisation of the body provided the basis for its modern development as a scientific, medical and lifestyle commodity. Consequently, cosmetic surgery has a dual meaning as both a medical and a lifestyle event. Richard Jobe, a plastic surgeon, had constructed his clients as the ideal consumers - 'sophisticated shoppers' embarking on 'an aesthetic, cosmetic surgical adventure' (Jobe 1990: 20). While this view of cosmetic surgery disrupts cultural ideas about the 'natural' body, the cosmetic surgery industry itself is embroiled in a series of internal debates that disrupt the cultural presentation of cosmetic surgery as an unproblematic medical event. Moreover, the term 'industry' tends to imply that the cosmetic surgery profession is a uniform and monolithic entity. The following section considers some of these internal debates and attempts to deconstruct the 'industry' by exploring the micro-organisation of cosmetic surgery in Christchurch, New Zealand.

### 4.3 THE POLITICAL ECONOMY OF PLASTIC SURGERY

Plastic surgeons practise within a profession that is challenged in at least three significant ways. First, the professional legitimacy of plastic and/or cosmetic surgery practitioners is challenged. Then there are debates about the safety and effectiveness of a particular cosmetic surgery procedure (for example, autologous fat transfer or silicone-gel breast implants). A third contested area relates to distinctions between plastic reconstructive surgery and aesthetic cosmetic surgery and the availability of medical insurance cover for clients having these procedures.

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<sup>6</sup> See Section 3.1

There are six surgeons engaged in private practice cosmetic surgery in Christchurch. One of the plastic surgeons is a woman. Four of the surgeons are based permanently in Christchurch, and the remaining two are visiting surgeons who return to Christchurch periodically to perform pre-booked surgeries. The plastic surgeons based permanently in Christchurch are registered with both the New Zealand Association of Plastic and Reconstructive Surgeons and the New Zealand Foundation for Cosmetic Surgery. They offer aesthetic surgery in addition to plastic and reconstructive surgery and for the purposes of this section of the chapter will be referred to as the 'plastic surgeons'. The non-resident cosmetic surgeons, referred to here as Dr Alpha and Dr Beta<sup>7</sup>, perform aesthetic cosmetic surgery exclusively, and are not registered with either of the above New Zealand organisations. Dr. Alpha claims association with an Australasian cosmetic surgery organisation, while Dr. Beta advertises membership with two American cosmetic and plastic surgery associations. Dr. Beta advertises exclusively for liposuction clients. Dr. Alpha's advertisements also target liposuction clients, but in addition offer other cosmetic procedures including nose reshaping, bat ear correction, cheek enhancement and hair transplantation. In the following discussion they will be referred to as the 'cosmetic surgeons', a subtle distinction which in the context of New Zealand medical politics becomes vitally important.

The plastic surgeons operating through the New Zealand Medical Council have challenged the 'right' of 'unqualified surgeons' to perform cosmetic surgery in New Zealand. This challenge is directed primarily at doctors who have trained to be 'cosmetic surgeons' outside New Zealand. The importance of the difference between these surgeons is illustrated by this extract from an interview with a 'plastic surgeon' (P.S.):

P.S.: The person...is not a plastic surgeon.

SP: No, he is a cosmetic surgeon(?).

P.S.: He is not a cosmetic surgeon.

SP: He calls himself a cosmetic surgeon.

P.S.: No, not a surgeon, not a qualified surgeon, that is very bad, ...he is a general practitioner, there is no surgical qualifications

(Plastic Surgeon 1: 14/07/93).

The plastic surgeon articulates his concerns about doctors who perform cosmetic surgery procedures with no formal surgical training. While the doctors argue that this is a safety issue for clients, it is also a dispute over

<sup>7</sup> This information is publicly available. However as permission has not been sought to use their names in this thesis they are referred to respectively as Doctors Alpha and Beta.

professional boundaries and access to clients or potential clients. The debate surrounding professional legitimacy is also apparent in the United States. Jobe defines 'a real plastic surgeon' in the following way:

A real plastic surgeon,...is a full-time plastic surgeon, who has graduated from an approved medical school. This must be followed by at least three years of training as a general surgeon...(ear, nose and throat is suggested as a good related prerequisite)...to the minimum 2 years of full-time residency in Plastic Surgery (Jobe, 1990: 3).

Jobe distinguishes between the 'plastic' and 'cosmetic' surgeons in terms of their surgical qualifications and he also criticizes the 'cosmetic' surgeons in relation to their business practices. For example, Jobe suggests real 'plastic' surgeons do not advertise aggressively:

...advertising beyond the courtesy listing in the yellow pages is an anathema, an inappropriate behavior...Few plastic surgeons of substance advertise (Jobe, 1990: 14).

For Jobe plastic surgeons provide a consultative service, they do not run a business:

A surgeon becomes a businessman [*sic*] when he [*sic*] recommends an operation of questionable or no value to the patient, or when he suggests he perform a surgical procedure on a person when there are distinctly better trained and/or more experienced surgeons available (Jobe, 1990: 16).

While the plastic and cosmetic surgery industry is necessarily a business enterprise, the plastic surgeons prefer to see themselves as providing a non-commercial professional consultancy service, refusing to suggest or perform 'unnecessary' cosmetic surgery procedures and referring clients to the best surgeon for their desired aesthetic operation. Jobe's 'sophisticated shoppers guide to cosmetic surgery' not only distinguishes between legitimate and illegitimate cosmetic and plastic surgeons, but also constructs the respective cosmetic surgery clients as sophisticated and unsophisticated. For Jobe, sophisticated clients are those people who seek information and consult widely before choosing a plastic surgeon. Unsophisticated clients are those who employ the services of an 'unqualified' surgeon, do not consult widely and are easily persuaded to have unnecessary combined (or multiple) cosmetic surgeries (Jobe, 1990: ix).

The second contested area involves the safety and effectiveness of a particular cosmetic surgery procedure. The most well known controversy in this area is the silicone-gel breast implant debate. This controversy provides the overall

framework for a discussion of cosmetic surgery as a form of exploitation in Chapter Five. Another cosmetic surgery procedure that is currently subject to dispute within the medical profession is autologous fat transfer or 'natural' breast enlargement. This procedure involves the removal of unwanted fat via liposuction and the re-injection of the refined fat cells to recontour different parts of the body, in particular, the breast, penis and face. This cosmetic procedure is not sanctioned by the 'plastic surgeons', and in terms of providing cosmetic surgery services, differentiates them from the 'cosmetic surgeons':

There is no such thing as natural breast enlargement...it is your own tissues yes, but it does not take as a graft. It is potentially dangerous because a woman might have a lump, have a mammogram, her lump is diagnosed as breast cancer, the breast removed, analysed and no breast cancer, it is only (dead liquid fat and fibrous tissue encirculated in ) scar... It is very dangerous and no plastic surgeon in New Zealand would do this, no responsible plastic surgeon would do that (Plastic Surgeon 1: 14/07/93).

The plastic surgeons use their professional authority to argue against a procedure they consider to be unsafe for women. They imply that the 'cosmetic' surgeons are more interested in making money and that this translates to a lack of proper concern for their clients' long-term welfare. In contrast Dr Alpha advertises that he is a 'highly skilled and internationally trained cosmetic surgeon'; he disagrees that 'liposuction should be carried out only by a plastic surgeon'. Dr Alpha performs up to 1200 liposuction operations per year and suggests the plastic surgeons' concerns arise out of 'professional jealousy' (*The Press*, 16/4/1991).

The third area of contention relates to distinctions between reconstructive/plastic and aesthetic/cosmetic surgery and its relationship to the availability of private medical insurance cover for clients having these procedures. In New Zealand medical insurance companies will not 'pay for cosmetic surgery, which is considered elective and medically unnecessary' (*More* 07/07/93). Insurance companies consider most breast operations to be a cosmetic surgery procedure. However, there are anomalies in what insurance companies are prepared to cover. One insurance company would not pay for a woman's breast reduction, but covered the cost of her physiotherapy for back pain resulting from her large breasts. Another insurance company covered 'the removal of a fibrous mass from one breast, but refused to pay when the other breast was reduced to match' (*More* 07/07/93). While medical insurance companies rigidly differentiate between plastic surgery and cosmetic surgery, problematising the plastic/cosmetic surgery dualism allows for more fluid or ambiguous



interpretations of the similarities and differences between cosmetic and plastic surgery.

The problem lies in the definition of cosmetic surgery. In Chapter Two<sup>8</sup> I problematised the constructed opposition between 'legitimate' plastic and reconstructive surgery and 'illegitimate' aesthetic/cosmetic surgery. I argued that this binary opposition is discursively constructed and based on assumptions about what is normal/abnormal, and/or natural/artificial, in our culture. There is also considerable ambiguity within medical definitions of plastic and cosmetic surgery. In the following conversation a plastic surgeon interviewed talks about distinctions between plastic surgery and cosmetic surgery:

...between plastic and aesthetic surgery... there is a vast distinction in our minds. Plastic surgery in that sense is reconstructive surgery, it is reconstructing things...as a result of injuries or disease... Aesthetic is pure cosmetic surgery ...Although we would go for a cosmetic result in all operations, that we try and do reconstructive surgery with a good cosmetic result. And I suppose in that sense aesthetic surgery is purely surgery to enhance beauty (Plastic Surgeon 3: 22/04/94).

According to this plastic surgeon there are significant cognitive distinctions between plastic surgery and cosmetic surgery ('vast distinctions in our minds'). Plastic surgery is discussed in relation to reconstruction aimed at correcting an impairment, while cosmetic surgery is talked about as 'purely surgery to enhance beauty'. However, the plastic surgeon also clouds this distinction by suggesting that the best reconstructive outcome is one that is not only functional but also has a 'good cosmetic result'. At a more abstract level discourses surrounding both plastic and cosmetic surgery prioritise aesthetic 'rectification' over non-intervention, and reflect difficulties in the acceptance of differences between individuals based on appearance.

Material differences between plastic and cosmetic surgery techniques are similarly ambiguous. In the following conversation the plastic surgeon interviewed discusses similarities and differences between cosmetic surgery and plastic surgery techniques:

There is a general difference... some surgery we do is purely reconstructive ...and then there is some that is purely cosmetic and not really reconstructive at all, but there are very different overlaps and a lot of the principles you use in reconstructing - congenital, trauma, cancers - is applied in the cosmetic area and vice versa. So a lot of the work... involved with treatment of cosmetic problems is equally applied to

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<sup>8</sup> See Section 2.6.

other...reconstructive problems, and some of the reconstructive techniques are quite useful when you are doing cosmetic techniques (Plastic Surgeon 2: 21/04/94)

While there are 'general differences' between plastic and cosmetic surgery techniques, this plastic surgeon suggests there are also considerable 'overlaps'. According to the plastic surgeon, most cosmetic surgery techniques can be used in reconstructive surgery (and some reconstructive surgery techniques are useful when doing cosmetic surgery). The ambiguity surrounding medical definitions of plastic surgery and cosmetic surgery is thus reflected in the talk of the plastic surgeon interviewed.

Generalisations about plastic and cosmetic surgery obscure rather than clarify the way in which these discourses and practices are created and applied to the body. Since plastic surgery is considered to be more legitimate than cosmetic surgery, these differences have been used to discredit those people who provide or use cosmetic surgery. Distinctions between plastic and cosmetic surgery are based on assumptions that the boundaries constituting these two categories are fixed and unambiguous. In New Zealand private practice plastic surgeons perform both plastic/reconstructive and aesthetic/cosmetic surgery procedures. Differences between these two forms of surgery are discursively constructed rather than grounded in any obvious differences in technique, or desired outcome.

The opposition between 'legitimate' plastic and 'illegitimate' cosmetic surgery is also apparent in contemporary discourses and practices surrounding plastic surgery<sup>9</sup> and in the policies of insurance companies. For example, in New Zealand not all insurance companies will pay for a breast reconstruction following mastectomy. Similarly, despite its name, the majority of medical practitioners would consider a breast reconstruction to be an aesthetic/cosmetic procedure rather than plastic/reconstructive surgery<sup>10</sup>. Breast reconstruction receives a low priority within the public health sector; it is considered an elective surgical procedure because a woman's physical mobility is not greatly impaired following mastectomy<sup>11</sup>.

The boundary between what is termed a strictly 'plastic' and what is a strictly 'cosmetic' surgery procedure becomes particularly blurred when it is applied to

<sup>9</sup> See Chapter One, Section 1.2 for a discussion of print media texts on cosmetic surgery and Chapter Three, Section 3.3 for a discussion of breast reconstruction.

<sup>10</sup> See the discussion of breast reconstruction in Chapter Three, Section 3.3.

<sup>11</sup> Although some women experience a loss of balance following mastectomy, this can be corrected by using an external breast prosthesis.

the breast. Since breasts tend to be constructed as icons of femininity, any elective modification of the breast tends to be viewed as an enhancement of femininity as opposed to restoration of 'normal' appearance<sup>12</sup>. Pamela, a former breast cancer patient, believes all women should have access to a breast reconstruction regardless of ability to pay:

...the only way you can get it (a breast reconstruction) done is if you have got money or insurance. That is one concern to me, it is very unfair, because I think it should be something that is automatic if a woman wants it... A lot of women can't afford it,... I think it cost about eight thousand dollars for mine... (but) it only actually cost me five hundred dollars because insurance paid for most of it... Even if you didn't have a lot of money you could afford five hundred dollars, you could take out a loan if you had to, because it would not be too difficult to pay back the money. But I think it is very unfair because there must be lots of women who can't do that because they don't have medical insurance (Pamela: 25/10/93).

Pamela would like the state to recognise breast reconstruction as a woman's right and to fund it within the public health system accordingly. The plastic surgeons consider access to their services can be improved through increasing clinical autonomy and by providing independent services from the state. The private practice plastic surgeons would like to see insurance companies provide more flexible insurance cover for their clients based on clinical assessments of what constitutes a 'necessary' cosmetic and reconstructive procedure (*More*, 07/07/93).

Cosmetic surgery can be viewed as a disputed profession practised by autonomous agents at a series of fragmented sites or locales. Rather than existing as a monolithic entity, organised through a systematic and coherent industry, cosmetic surgery practices are located in the number of contradictory ways in which cosmetic surgery discourses and practices are produced, supported, circulated and enacted within medicine and popular culture.

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<sup>12</sup> Following an accident the government funded Accident Compensation Corporation (ACC) will meet the cost of a 'breast reconstruction with implant'. However, access to this operation is subject to normal ACC criteria. Firstly, the client must gain prior approval for the operation from ACC. Secondly, the client must pass the principle economic activity test (ie. it must work out cheaper for ACC to pay for the surgery to get the client back to work as opposed to providing the client with a set amount of compensation each week.). Very few women would qualify under these criteria, firstly as they would have to prove inability to work because of psychological distress resulting from the mutilation of their breast(s) and secondly because the policy leaves all people outside the workforce without accident cover (Claims Officer, ACC, Christchurch, Dec. 1993).

#### 4.4 MEDICAL DISCOURSES AND THE (RE)CONSTRUCTION OF FEMININITY

The opposition between naturalness and artifice in the construction of more (natural?) feminine shapes for women via cosmetic surgery technologies can be explored through the discourses and practices of the plastic surgeons. According to Dull and West (1991) plastic surgeons act as the technological and cultural gatekeepers in the hegemonic presentation of gender:

In offering accounts of their surgical decision-making, surgeons uphold normative attitudes and activities for particular sex categories and, hence, become co-participants in the accomplishment of gender. In addition surgeons act as technological facilitators of gender's accomplishment and as cultural gatekeepers in the fine tuning of gender's presentation. Thus, cosmetic surgery emerges as an institutional support for "doing gender" (Dull and West, 1991: 68).

Medicine provides an institutional support for the formation and attachment of certain gender identities to particular bodies. Most of these identities are based on normative ideals of femininity and masculinity. The remainder of the chapter attempts to engage with the way in which aspects of 'doing gender' are institutionalised through the discourses and practices of cosmetic surgery.

Cosmetic surgery technologies are marketed to women in terms of their search for correct body image, deportment and posture, their practicality, comfort and naturalness. At the forefront of cosmetic surgery technologies is a trend towards the development of surgical techniques that reconstruct the body with minimal evidence of scarring. New advances in cosmetic surgery technologies are quickly reflected in cultural texts which present an increasingly flawless standard of feminine beauty. However cultural ideals do not just emerge in some conspiratorial ad-hoc way; they are progressively developed over time through actual social practices. According to Treichler:

Physicians did not uniformly declare a war on nature, nor decide that they should adopt an ideology of intervention and subordination of women. Ideology is lived, not simply created and flung over society like a great net (Treichler 1990: 118).

In Chapter Two<sup>13</sup> I discussed how the Foucauldian concept of bio-power is implicated in the formation and attachment of certain identities to particular bodies. Foucault's theories engage with the way in which knowledge/power inscribes on the body a certain way of being. Using the Foucauldian model, it

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<sup>13</sup> See Section 2.4 and Section 2.5.

is possible to reflect on the way that discursive practices, such as those deployed by the surgical corsetiere and the cosmetic surgeon, (re)produce, (re)construct and mobilise certain ideals of femininity which describe and inscribe the female body. Foucault's insistence that the body is an historically specific entity, discursively constructed within culture and governed through institutionally sanctioned techniques of surveillance and control (Foucault, 1978: 139-148) is played out literally in the practices of the plastic surgeon.

Statements from plastic surgeons communicate some of the ways in which they employ techniques of surveillance and control to produce regulative strategies that enforce particular definitions of the body as either ideal, normal, abnormal or deficient. Medicine as an institution sanctions the techniques of surveillance and control deployed by the plastic surgeons and provides the institutional support for doing plastic surgery. In the following extract from a conversation with a plastic surgeon, the surgeon employs a particular understanding of the normative body to explain the difference between aesthetic/cosmetic surgery and plastic and reconstructive surgery:

Do I make a distinction between plastic (and cosmetic)? I believe plastic is plastic and reconstructive surgery, yes that is restoring what is outside the normal towards normal, and cosmetic and aesthetic surgery is taking something inside the range of normal and going towards the mean (Plastic Surgeon 1: 14/07/93).

According to this plastic surgeon, cosmetic surgery technologies target the 'normal' body. In contrast, reconstructive surgery technologies target the 'abnormal' body. In order to deploy this opposition, individual plastic surgeons have to make a distinction between what sorts of body shapes and features fall into the range of normal and abnormal. One of the plastic surgeons I interviewed based this distinction on whether the person had sustained an injury or not:

...a plastic...or...reconstructive surgeon is able to analyse a defect in a war wound for example, and then design an operation which will transfer (or blend in) these missing tissues from other places to reconstruct the defect. Cosmetic and aesthetic surgery is taking what a person is born with and making them more towards the norm. For example people may be born with a whole range of imperfections, if you take a breast for example, going from too small, to average, to too large, and everyone wants to be the norm...So we are able to take people in this range of normal and make them more towards the mean (Plastic Surgeon 1: 14/07/93).

Foucauldian theory places the notion of the 'norm' at the centre of the functioning of bio-power and the disciplinary techniques of control associated

with the body (Grace, 1989: 245). The plastic surgeon interviewed employs medical technologies to reconstruct 'abnormal' bodies and to sculpt 'normal' bodies so they may approximate more closely to the 'mean' or 'ideal'. However, in distinguishing between plastic and cosmetic/aesthetic surgery the plastic surgeons can also disrupt the opposition between normal and abnormal bodies which is presented as the dominant reading of cosmetic surgery within cultural texts. The following extract from a magazine provides an example of this reading of cosmetic surgery:

"My personal definition of 'cosmetic' surgery is that it's the patient trying to better what they can't be naturally. But if you're trying to be what society sees as the norm, that's hardly (a) cosmetic procedure" (Dr Pat Beehan quoted in *More*, 07/07/93).

Dr Beehan suggests that cosmetic surgery operations are 'hardly cosmetic'. In doing so he disrupts the constructed opposition between necessary plastic and unnecessary cosmetic surgery<sup>14</sup>. In the following conversations two plastic surgeons talk about scarring. The first suggests the scarring that occurs as a result of breast reconstruction surgery is less than perfection, while the second considers that a scar is inevitable:

PS1: ...a plastic surgeon is aiming for perfection, but almost never can make it as good as the natural breast, and almost never up to the expectations of the woman expecting to have perfect breasts with no scars... (Plastic Surgeon 1: 14/07/93).

SP: Is 'scarless surgery'<sup>15</sup> available in New Zealand?

PS2: You can't do surgery without making a scar (Plastic Surgeon 2: 21/04/94).

The plastic surgeons interviewed operate within a framework of "scientific progress", decisive clinical action and professional autonomy. Their conversations about the scarring that occurs as a result of cosmetic surgery suggests that for most people the achievement of cultural representations of the feminine or masculine ideal as a 'natural' form of embodiment is impossible.

The discourses and practices of plastic surgery aim at producing a standardised bodily image (Smith, 1990: 187). Plastic surgeons have the power to define, establish and enforce a particular ideal of female beauty on the basis of their

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<sup>14</sup> I also talked informally to two general surgeons both of whom suggested that all cosmetic surgery assessed and performed by a qualified plastic surgeon was "necessary".

<sup>15</sup> Sometimes referred to as keyhole surgery, laproscopic surgery is often promoted within the media as 'scarless surgery' when used for cosmetic surgery procedures. See: 'Scarless Surgery: ...breast implants inserted through your navel, ...all through a new revolutionary form of surgery without scars'. *Cleo*, October, 1993.

status as medical professionals. This power to define the ideal female form is illustrated by the description below of how a research team developed a measurement for the 'ideal' breast:

...we had to find out where the nipple was in the ideal woman, and so we asked a number of attractive looking young nurses to allow us to take some measurements as to where the nipple should be and we took their height and chest dimensions, you know around the chest, where abouts the nipple was in that person, in the ideal shaped breast, and...it proved to be quite constant...it ranged between 20cm to 22cm, no matter if you were petite or very tall there was only a small difference in height...We tried...properly proportioned women, young women, nubile, who hadn't had children in other words should be in ideal shape (Plastic Surgeon 1: 14/07/93).

According to this plastic surgeon, the size and shape of the 'ideal' breast is dependent on the placement of the nipple. A specific distance, located 20 to 22 cm below the centre of the breast bone on each side body is deemed to be the correct site for the placement of the nipple. In the above example the plastic surgeon constructs for women a measurement for a 'normal' breast based on certain medical and cultural ideals about what images of the breast are most pleasurable and desirably feminine.

The measurement of the ideally shaped breast is constructed and legitimated through the medical examination. The men participating in the research determined which of the nurses had breasts that were ideal and therefore qualified for measurement. The 'ideal shaped breast' is the non-lactating breast of a nubile, properly proportioned, young woman. The acts of measurement and the precision of the results conceal the idiosyncratic and contingent judgements of the surgeons about 'the ideal woman'. The body of an 'ideal woman' is not the body of a large or older woman, nor is it the body of a mother. The ideal, determined by age, shape and reproductive non-functioning, effaces the material reality of the female body. By deconstructing the way operations of power define the body these definitions emerge as social constructs.

The social construction of the 'ideal' female body is made explicit in the way in which the plastic surgeons I interviewed talk about breast augmentation. Table 4.1 compares two plastic surgeons' discussion about sizing techniques for breast augmentation. The first plastic surgeon (PS2) talks about how he uses the bra as a measurement standard, while the second plastic surgeon (PS3) reveals that he prefers to work from magazine photographs provided by clients. Both of the plastic surgeons explain how they use their client's perceptions of

'ideal' breast size, either in relation to bra size or "girlie" magazine photographs, to enlarge the breast. Since the dominant discourses and imagery surrounding the female breast tend to suggest that larger is better (see Fig. 1.1: page v), client-centred definitions of the 'ideal' can be read as conforming to images of femininity that are culturally constructed. For most Western women bra size had become the standard against which a majority of women and (heterosexual) men measure and/or eroticise the female breast. The attractiveness of the female breast is measured against this numerical index of bra sizes.

Plastic Surgeon 2	Plastic Surgeon 3
With augmentation I...always get the women to go out and buy a bra the size they want to be, and we then work out what size of implant we need to put in to achieve that size. If we are not sure if it needs to be a 180 or a 200cc implant we will get both of those and try them on the operating table. We will sit her up and we will get the anaesthetist and the nurse to have a look and see what they think. If we are not sure I tend to take the smaller one. So that is how we do augmentation (Plastic Surgeon 2: 21/04/94).	Augmentation is very difficult because there is no accurate sizing measurement technique. So what I normally do is get people to bring me photographs from girlie magazines to give me some idea of what they think they should look like and then I can judge from that. But I get it wrong, sometimes they say it is too big, sometimes they say it is too small, but there is no other way really of doing it accurately. There are some prosthesis models that you can use...but it is very rough and ready (Plastic Surgeon 3 22/04/94).

Table 4.1: From 'ideal' to 'real': Sizing techniques for breast augmentation.

Plastic surgeons tend to construct themselves as experts who decide what body shapes and features fall into the category of an aesthetic "defect":

Many of us, probably all of us, have some "defect" that could be improved by an aesthetic surgeon if we had the proper concern, the nerve and the interest to have something done about it (Jobe 1990: 25).



According to Jobe, potential clients often present to him with 'improper' concerns about a body feature which he considers to be unimportant, and that their concerns would be better directed at a more obvious feature:

It is dangerous to guess why a new patient has come to the office of a plastic surgeon. Frequently, the patient will have a large nose or other feature which begs for the services of the surgeon, but will wish attention to something totally unexpected and often seen as unimportant by the surgeon (Jobe, 1990: 20).

Jobe's cautionary advice for aspiring plastic surgeons suggests that it is inappropriate to suggest a different surgery to a potential client as this could provide the person with a complex about the particular feature in question. Plastic surgeons are able to use the full weight of their professional medical authority to deploy their particular definition of an aesthetic "defect", and they are well aware of the social and psychological power of their judgment. The plastic surgeons interviewed also indicate that they have to ensure that potential clients show 'correct concern' for their body image. In this sense they are arbiters of 'a distorted body image':

It is very important that a plastic surgeon and the patient... must have correct body image... it is very important that a plastic surgeon has to know what a person's perception of their body is, and that patient's perception corresponds with what the plastic surgeon actually sees. So if a patient comes to me, very slim and had really nice contours and does not look fat to me at all, and the patient is asking for liposuction, for example, I would say: 'Please do not have liposuction because you are the right weight for your height, and the fat is distributed in the right places, you are nicely covered, that is supposed to be like that, please do not have anything done'. So a person with a distorted body image may be presenting to me for cosmetic surgery and I would tell them not to have anything done (Plastic Surgeon 1: 14/07/93).

This plastic surgeon provides an insight into the way he applies idealised versions of female shape to women who are potential clients. These ideal versions of female shape are based on visual appraisals of the distribution of body fat and assessments of what constitutes the right weight to height ratio. Like Jobe, this plastic surgeon constructs himself as not taking money for 'unnecessary' work, and as providing a non 'commercial' consultative service. He also reveals that to be a good candidate for cosmetic surgery a potential client has to meet his standards of 'fat', 'malformed' or 'defective'. As they make these judgements, the plastic surgeons construct norms of femininity through a gaze that is both medical and male. The process of linking ideals of femininity to the way cosmetic surgery is used to rework the female body, is also demonstrated in the way plastic surgeons make judgements about appropriate breast size. In the following conversation the plastic surgeon

interviewed discusses the range of breast augmentation and reduction options available at his clinic.

I make them decide how big they think they ought to be. If they are completely beyond the range of what is achievable, I mean somebody comes in and they bring in photographs of Dolly Parton, I don't get into that, right. Or if people with double E cup bra breasts wanting an A cup, I tell them it is not possible. I've had women who have said just take them completely off, of course, you don't do that, because when you have reduced their breasts adequately they actually say, 'that's... fine, that is good'. But I try and make them be accurate in asking what they think they want. It is not for me to tell them what they should have... (Plastic Surgeon 3: 22/04/94).

This plastic surgeon discusses the boundaries of what he considers to be appropriate and inappropriate ways of remoulding the breast. These boundaries are constructed in relation to what he believes to be realistic and 'achievable' options. These options are based on what breast sizes he feels comfortable with ('I don't get into that') as opposed to what the women may actually want. Moreover, the achievable options outlined by the plastic surgeon are based on his visual perceptions of, and personal opinions about, 'normal' breast size. This plastic surgeon reveals that he will not recraft the breast in a way that will attract improper attention to his female clients. Implicitly this plastic surgeon suggests it is the clients who push the boundaries of what the surgeons are prepared to do. Jobe also suggests that the worst clients, because they are the hardest to please, are those people who have cosmetic surgery because they desire the 'social effect' of their surgery<sup>16</sup> (Jobe 1990: 20). Cosmetic surgery might be a negotiated process, whereby the client's perception of what should be done and the surgeon's perception of what is technologically possible and aesthetically appropriate must coincide before the surgery can be performed. This process is demonstrated in the following conversation with Lucy, a cosmetic surgery client whom I interviewed in Christchurch in 1991:

Lucy: I had no choice about the size of the breasts that I wanted, and that was something that surprised me, because I thought that I could go in, 'right I'll have a thirty four A thanks or a double A if I'm lucky' ...and I said (to the surgeon): 'What's the story about the size?' And he said, 'well I make that decision really at the time'. And that is when I thought: 'Well actually I don't want a man to make the decision about the size of my breasts'. But he said that he based that decision on the body shape and what was appropriate, because... most women wanting a breast reduction would be wanting a very inappropriate size breast, for example, me wanting a thirty

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<sup>16</sup> I talked informally to a general surgeon, who had done some intern training in the plastic surgery field. He confirmed that it was important to understand a potential client's motivation for their surgery and to screen out those clients who wanted cosmetic surgery in order to gain social approval. He suggested this group of people tended to have unrealistic expectations, and were more likely to return to their plastic surgeon expressing dissatisfaction with the aesthetic results of their surgery.

four A or an A cup you know... that would be absolutely no breast for me... which is what I wanted... to have 'nothing, chop it off thank you'... (Lucy August 1991).

Lucy objected to a male surgeon deciding what size her breasts should be and attempted to push the boundary of how much the surgeon was prepared to reduce her breasts. Lucy's account of this interaction suggests she was simultaneously colluding with and resisting the reconstruction of her body in relation to the norms of femininity deployed by the cosmetic surgeon. She provides a good example of how women who engage with cosmetic surgery can construct themselves as active agents choosing to remake themselves in various ways. However, Lucy's agency is also constrained within the context of a variety of institutional regimes and sets of normalising assumptions and practices that are constructed and inscribed by the plastic surgeon and reinforced through cultural texts. Cosmetic surgery illustrates how women can be constructed as both subjects and objects, makers and made, empowered and subjugated, active and passive.

In Chapter Three<sup>17</sup> I explored the subjective and discursive practices of women who had cosmetic surgery. I suggested that the women with whom I talked simultaneously embraced and resisted dominant explanations of cosmetic surgery available to them in the mass media. The comments of a plastic surgeon I interviewed are often consistent with the reasons women gave for using cosmetic surgery. In the following discussion the plastic surgeon describes the transformation of young women who have breast reductions in relation to the lifestyle, personality and mobility benefits of their surgery:

An 18/19 year old girl would come in here sit in front of me with a loose fitting jersey on, hunched shoulders, head down. After the breasts have been reduced to an acceptable size for them, suddenly they come back in three or four months time and they are standing straight, head up, shoulders back, wearing looser fitting clothes, even their outward appearance makes them look more self assured and not as withdrawn and they are more outgoing. So it affects them not only psychologically but you can see this in their [ ] body [ ] language and how they move themselves (Plastic Surgeon 1: 14/07/93).

The plastic surgeon acknowledged that cosmetic surgery not only surgically alters the body, but is also a means of transforming the self by recrafting an individual's identity. This Christchurch plastic surgeon suggests that women in different age groups have different reasons for seeking a breast reduction or enhancement and that they receive different benefits from their surgeries:

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<sup>17</sup> See Section 3.3

S.P.: Are women of different ages presenting for different procedures?

P.S.: Obviously this would be so... there are young women... presenting with versional hypertria of the breasts... and they require breast reduction, whereas a woman who had had two or three children and the volume of the breast has deflated... may be presenting for a mastopexy that is a breast reshaping operation. Yes, so any procedure you can think of there is an age range in which those people would be presenting (Plastic Surgeon 1: 14/07/93).

The plastic surgeon suggests that older women who down-size their breasts receive the most benefit in terms of the actual reduction in the size and weight of the breast. In addition the women are able to wear more tailored clothes. However, in comparison to the younger women, the older women's surgery is constructed as being less successful in terms of its ability to bring about lifestyle, personality and motility changes.

...people aged 50/60 years old, they have got some disposable income of which to do something for themselves... These people have put up with heavy breasts all their life... and the heavy breasts have been cutting into the shoulder with the bra straps... the posture is bad and they have never been out-going and this has become a personality trait which has become ingrained. So they come along for a breast reduction and certainly the size of the breast is less and they can fit into clothes which are more tailored for them, because the weight of the breast has gone their posture can improve to some extent and perhaps the pains in the back ...neck... and shoulders may go to some extent, but of course there has already been this pathological change (in the spine) going on for 30 years or so, the chances of change is then not so great. These 50 to 60 year old women often are smartly dressed and want to look good amongst all their friends (Plastic Surgeon 1: 14/07/93).

According to the plastic surgeons I interviewed, young women want to be active, women who are over thirty and have an established career want 'self assurance' and to be competitive while women nearing retirement age want to be 'smartly dressed'. Lifestyle changes are emphasised relative to the actual surgical changes involved in reducing a breast.

While cosmetic and plastic surgeons deploy notions about 'natural' breast shape, it is possible to identify contradictory discourses in the statements and practices of the plastic surgeons about achieving this 'natural' breast shape through the use of invasive surgical procedures (see Table 4.1 and Table 4.2). The discourses used in the promotion of breast surgery emphasise the achievement of 'normal' appearance in women whom they designate as having 'abnormal' or 'defective' breasts. Plastic surgeons construct certain groups of women with particular breast sizes as needing a breast operation in order to approximate to the standards of femininity which are, at least in part, set by the plastic surgeons. These images and definitions appear to be shaped by

ethnicity the plastic surgeons interviewed tended to have primarily middle class non-Maori clients.

According to Kathryn Pauly Morgan, the transforming of oneself through cosmetic surgery is a form of 'racist' 'oppression' based on the cultural normalisation of the body (1991: 36). Susan Bordo also suggests that cosmetic surgery is one example of the way the body is controlled and reconstructed in relation to cultural ideals that homogenise racial, ethnic and sexual "differences". For Bordo, cultural ideals set limits on the way difference is validated within Western culture (1993a: 25).

However, exploring the forms of agency used by Maori women in choosing cosmetic surgery procedures suggests that the oppression model may over-emphasize analyses of cosmetic surgery as racist normalisation. Both Bordo (1993a) and Morgan's<sup>18</sup> assumption that cosmetic surgery is performed in a racist context was disrupted by one of the plastic surgeons I interviewed. He said very few Maori women presented to him for cosmetic surgery:

Maori women? ...Well I've had some for face lifts, a couple for liposuction, they come quite regularly for scar revision because they do not like scars very much and the odd one for eyelids. I've had one perhaps for a nose that they wanted to be made more Western - less broad and flat... Very few (Maori) really come for cosmetic surgery. Not many for augmentations, one of the ones I had augmented felt so badly about it she came back a couple of years later and had them out. It went against the Whanau... (Plastic Surgeon 3: 22/04/94).

According to this plastic surgeon, Maori women were under-represented for purely cosmetic surgery procedures, but were over-represented in the numbers of people opting for scar revision. In the New Zealand context the number of Maori women presenting to this Auckland plastic surgeon, and the types of procedures they chose, disrupts both Bordo and Morgan's generalised assumption of cosmetic surgery as racist normalisation. These plastic surgeons indicate that Maori women were unlikely to access cosmetic surgery technologies to change their ethnic appearance. When Maori did use cosmetic surgery they were more likely to choose procedures, like scar revision<sup>19</sup>, that restore 'normal' appearance and do not efface ethnic differences. Further, variations in the numbers of Maori opting for cosmetic surgery relative to 'Pakeha' cannot be explained solely by socio-economic factors some Maori

<sup>18</sup> Also discussed in Chapter Two Section 2.6 and Section 2.7.

<sup>19</sup> Lynne Poundsford, my office mate (and a Maori woman), went to a private plastic surgeon for scar revision in 1993, I am indebted to Lynne for her helpful comments on this section.

women did employ this plastic surgeon's services for reconstructive surgery procedures.

The plastic surgeons interviewed give medical legitimacy to 'common' sense ideas about their female clients. In this way the discourses and practices surround cosmetic and plastic surgery participate in developing, (re)constructing and institutionalising idealised versions of women's breasts - using notions of the 'ideal' breast which are different for women in different age groups. The next section compares the discourses and practices of cosmetic surgery with the way in which surgical corsetieres talk about 'doing breast work'.

#### **4.5 SURGICAL CORSETRY - "WE ARE SECOND ONLY TO THE PLASTIC SURGEON YOU KNOW"**

The discourses and practices of both plastic/cosmetic surgery and surgical corsetry focus on the achievement of a more 'natural'/'normal' breast shape through the use of artificial prosthesis technologies. In comparison to cosmetic surgery, which involves the transformation and reconstruction of the breast through invasive surgical technologies, surgical corsetry employs a range of external prosthesis technologies and corsetry techniques aimed at transforming, shaping and reconstructing the female breast. The following section briefly explores discourses and practices of the surgical corsetiere(s) and compares the words and practices of corsetieres and plastic surgeons.

In contrast to plastic surgery, which can be interpreted as an occupation dominated by men, surgical corsetry and the fitting of artificial breast prostheses can be described as a 'feminised' occupation, because the majority of people who do this form of 'breast work' are women<sup>20</sup>. There are two medically trained<sup>21</sup> surgical corsetieres in New Zealand. Both are women.

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<sup>20</sup> In Christchurch artificial breast prosthesis fitting services are provided by: an independent surgical corsetiere who runs her own practice, the Cancer Society and trained corsetieres in a local department store. None of the above locales employ men to do this work, and it is my understanding that there are no males working in this field in Christchurch.

<sup>21</sup> In the following conversation with one of the surgical corsetieres I interviewed, the corsetiere describes her medical training in Auckland over forty years ago:

The training involved the fitting of garments, approach to the customer, your understanding of her, and how to listen. Of course we had to be trained in anatomy and all the things to do with the human body, it was quite a course in psychology, and in all the surgical work our tutors were nurses and doctors. You had to learn to know what garment was for what complaint. Spinal problems, prolapses, apendectomies, abdominal problems, dropped

However there are many women who have no formal medical training in surgical corsetry and are also able to fit external breast prostheses.

In Christchurch the 'medically qualified' corsetiere and the 'medically unqualified' women who fit breast prostheses have an excellent working relationship and do not mind referring clients to one another. Nevertheless, in talking to women who have external breast prostheses, it appears that surgical corsetieres are able to provide a more comprehensive and faster service than the other women who fit the prostheses. The surgical corsetieres are able to use their professional medical authority to manipulate government funding for the provision of breast prostheses to women who have had partial or full mastectomies. Surgical corsetieres are often successful in gaining funding for a client's breast prosthesis when approval for funding has been withheld by their surgeon. For example, one woman I talked to said her surgical corsetiere had given her advice on how to obtain funding after the female surgeon, who performed her double mastectomy, did not consider her 'deformed' enough to qualify for the government prosthesis subsidy.

An analysis of the discursive practices of surgical corsetieres reveals some striking similarities to the discourses and practices of the plastic surgeons, despite their critique of normalizing representations of women's bodies. The opposition between naturalness and artifice with respect to femininity also has its place in the discursive practices employed by the manufacturers and surgical corsetieres who sell breast prostheses to women. Like the cosmetic surgeons, the manufacturers and suppliers of prostheses make some implicit connections between ideas about 'natural femininity', breast size and body shape. Modern prosthesis technologies are marketed to women on the basis of their necessity for correct body posture and deportment, as well as their practicality, comfort, durability, naturalness and their similarity to the breast. As one surgical corsetiere explains:

I try to create the look that they want. Usually they have a choice based on comfort and appearance...I like to give my ladies a good figure, curved roads are more interesting than straight ones (Surgical Corsetiere 1: 6/11/92).

In this way the surgical corsetiere employs discourses that implicitly construct for women certain ideals about what images are most pleasurably and desirably feminine. Unlike the crude ceramic bead, cotton covered precursor of the

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kidneys, supporting limbs for amputees, training and fitting of breast prostheses and understanding their trauma (Surgical Corsetiere 1: 6/11/92).

modern prosthesis, manufacturers now employ a range of sophisticated technologies to create, and continually improve upon, a 'life-like' liquid silicone-filled imitation breast. Prostheses not only look like 'real breasts', but behave like them as well. In the past this 'behaving' was presumably a major advantage of reconstructive surgery over the external breast prosthesis. The latest range of prosthesis technologies from the United States include the following options for women: the bra-less stick-on prosthesis for full mastectomies, the prosthesis shaped to respond naturally to gravity, detachable prominent nipples and the shell prosthesis for partial mastectomies. In the following extract (see Table 4.2) the surgical corsetiere is explaining to an audience at a fashion show for women with mastectomies the advantages of the new external breast prosthesis that responds to gravity. Placed alongside her words is a quote from a plastic surgeon who explains why he likes to place the internal breast prosthesis under the pectoral muscle. Importantly, both the surgical corsetiere and the plastic surgeon explain their craft in terms of their ability to create a more 'natural' breast shape.

Surgical Corsetiere	Plastic Surgeon
...the new type of Amena's (brand of prosthesis) they are bringing out are quite triangular (more like pyramids) in shape...they are quite a different shape from the tear drop one, which is the original,...these are just molded, and if you lie down the whole thing just stays sitting up, whereas with the newer ones, when you lie down the whole thing lies down with you...so it is a very natural type of prosthesis... (Surgical Corsetiere 2: 24/11/92).	I've been using this method whereby we put the silicone prosthesis under the pectoral muscle. The cavity was made larger, so the prosthesis slops around in a cavity larger than the prosthesis. I like that because when the patients lies to one side the prosthesis slops to one side, and when they stand upright the prosthesis slops to the bottom of the pocket, so it has a very natural appearance and feel (Plastic Surgeon 1: 14/07/93).

Table 4.2: Creating The 'Natural' Breast.



The opposition between naturalness and artifice with respect to femininity is used both by the surgical corsetieres and the plastic surgeons in the promotion and use of breast prostheses. Both the surgical corsetiere and the plastic surgeon advocate the achievement of a naturally feminine shape through the application of an artificial breast prosthesis<sup>22</sup>.

Like the women targeted by beauty and cosmetics advertising<sup>23</sup>, women with mastectomies are constructed as needing a breast prosthesis (or reconstruction) in order to approximate to the standards of femininity which are in part set by the images and discourses produced by the manufacturers and advertisers of prostheses, who, along with the surgical corsetieres, implicitly construct for women certain ideals about what images are most acceptably, pleasurably and desirably feminine:

The basic thing is kindness, it is essential to do fashion work in addition to surgical work, because some people might come in and they do not know they have got a problem. *We are second only to the cosmetic surgeon, you know* (Surgical Corsetiere 1: 6/11/92 italics my emphasis).

Like the plastic surgeons, the surgical corsetiere defines the problems for women who do not conform to ideally feminine shapes. Alongside this the influence of the media also is pervasive in constructing an image of the female body as spectacle. Within popular culture, advertising and the media, femininity, pleasure and desire are overtly constructed according to certain narrow standards of aesthetic beauty and body size. Although the surgical corsetiere was actively involved in constructing a certain image of femininity for her 'patients' - an image based on her skill and ability to fabricate an illusion of a female breast - she was highly critical of the way in which images of femininity were often represented within advertising and the media. Referring to the current fixation on large female breasts within popular culture, the surgical corsetiere commented:

Breasts are for feeding babies, that is all they are designed for... When I was young, the emphasis was on the waist, if you had a waist more that 24 inches you were

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<sup>22</sup> Both the external breast prosthesis used in surgical corsetry and the internal silicone-gel/saline implant used in plastic surgery are referred to as breast prostheses by surgeons and corsetieres.

<sup>23</sup> Cosmetics and beauty advertising also contain contradictory discourses about achieving natural beauty through the application of artificial beauty products. Significantly, the discourses relating to cosmetic and beauty advertising are based on the enhancement and achievement of 'natural' beauty, while the discourses used in the promotion of breast prostheses emphasise the restoration of achievement of 'normal' appearance in women who have had mastectomies. Both discourses contain messages about how important it is for women to feel confident and good about themselves - especially in the way they are viewed by others.

overweight. Now the focus is on the bust, everyone wants large breasts. The point is, if there wasn't all this hoo-ha about bosoms (within advertising) people wouldn't be so concerned about body image. I think the media has a lot to account for... (Surgical Corsetiere 1: 6/11/92).

While this surgical corsetiere is highly critical of the way that women's breasts are currently represented within popular culture, she also nevertheless participates in reproducing idealised versions of women's breasts herself. Like the discursive practices surrounding cosmetic surgery, the discourses and practices she employs within her profession to construct an illusion of a rounded female breast, are based on the assumption that women are breasted, and that a woman's femininity is called into question when her breasts are absent, modified or deficient. The discourses used by the plastic surgeon interviewed and the two surgical corsetieres are simultaneously homogenising and individualising. While they are based on the notion that all women have breasts, they also assume that the breasts of individual women need to be measured, corrected and augmented according to a culturally defined standard of what constitutes an appropriate representation of the female breast.

#### 4.6 COSMETIC SURGERY AND THE AESTHETIC MASCULINE IDEAL

Feminist writing<sup>24</sup> about the beauty industry suggests that the high premium placed on female beauty within Western cultures has meant that women are more likely to seek cosmetic alteration in order to approximate to the ideals of femininity presented to them within the mass media than men are to seek ideals of masculinity. In contrast, it is implied that male beauty is not necessarily a measure of male success, nor a prerequisite for the achievement of the masculine ideal(s), and therefore men are less likely to seek the services of a cosmetic surgeon. Feminist writer Sandra Coney (1991) provides this summary of Susan Sontag's (1974)<sup>25</sup> analysis of the aesthetic 'double standard':

Middle-class European women place high value on health and their physical attractiveness. These are assets, important to their social status and their sexual marketability...Susan Sontag talks about 'the double standard of aging' women encounter whereby men's status and attractiveness is enhanced by growing older whereas women's is diminished...Sontag also points out that the money and power that can come at middle age add to men's value and make them more desirable. *What they*

<sup>24</sup> See for example Wolf (1990) pp. 93-95.

<sup>25</sup> Sontag, Susan (1974): Women grow old but men mature. *Broadsheet* 16: 6-7

*do rather than how they look determines their status.* (Coney, 1991: 18 italics my emphasis).

In Chapter One<sup>26</sup> I considered how men's bodies were discussed in popular magazines, and I looked at ways in which women might be encouraged to objectify men's bodies. The trend towards the fragmentation of men's bodies into a series of 'objectified parts' within popular culture is reflected in an increasing range of cosmetic surgery procedures aimed specifically at men, and in the numbers of men choosing cosmetic surgery as a means to transform and reshape their bodies. Currently it is estimated that one quarter of all cosmetic surgery procedures are performed on men (Finkelstein, 1991: 90). According to one of the plastic surgeons I interviewed, the ratio of male to female clients presenting to him for cosmetic surgery has remained static over the last ten years. A conservative estimate of the ratio suggests one in four of his clients are male:

I have not actually done the analysis, ...but I would guess it would range between 2/5ths males and 3/5ths females up to 1/4 males and 3/4 females (Plastic Surgeon 1: 14/07/93).

According to the estimate provided by this Christchurch plastic surgeon, New Zealand women are still three times more likely to seek cosmetic alteration than men. However, men have consistently comprised no less than 25 percent of the total number of people opting for cosmetic surgery. A similar male to female ratio is also reported in Australia (*Mode* October/November, 1993) and figures from the United States suggest that in 1987 fifteen percent of all cosmetic surgery patients were men (Faludi, 1991: 251). Increasing percentages of men opting for cosmetic surgery are noted in the following extract from a book on cosmetic surgery written by a female plastic surgeon:

...like most surgeons today, I am seeing a dramatic increase in male consultations. A third of my patients today are men (Moynahan, 1988: 182)

The percentage of men seeking aesthetic transformation in New Zealand and Australia is relatively high considering that this practice remains largely unsupported within hegemonic male culture<sup>27</sup>. This is the way in which one of

<sup>26</sup> See Section 1.3.

<sup>27</sup> See Bob Connell (1991): 'Live Fast and Die Young: The Construction of Masculinity among Young Working Class Men on the Margin of the Labour Market', *Australian and New Zealand Journal of Sociology*, Vol. 27, No. 2, August.  
also Lynne Segal (1990) *Slow Motion: Changing Masculinities, Changing Men*, London: Virago

the plastic surgeons I interviewed discusses the range of cosmetic surgery procedures used by men:

S.P.: What are men presenting for?

P.S.: Certainly for cosmetic surgery, they present for rhinoplasty, for bi-lateral ear operation, more recently perhaps for eyelid surgery, and about the same ratios for face lift surgery...I've had males for liposuction under the chin for example, and also males come in for tummy tucks... (Plastic Surgeon 1: 14/07/93)

This plastic surgeon confirms that men do have purely cosmetic surgery procedures, and have always done so in the time that he has been in private practice. Some men are employing surgical technologies to transform and shape their bodies. Today some men are not only using more traditional gender neutral technologies, such as rhinoplasty and bi-lateral ear operation, but are also employing cosmetic surgery procedures associated with the domain of women, for example face lifts and eyelid surgery. This suggests that some men consider that their status is determined by how they look and not just by what they do.

The development of surgical procedures aimed specifically at the transformation of men's bodies, alongside the increasing portrayal of more aesthetically oriented ideals of masculinity within the mass media, would suggest that the percentage of men seeking cosmetic surgery in New Zealand will increase in the near future. Cosmetic surgery for men is currently the fastest growing segment of the American cosmetic surgery market:

Pectoral-implant surgery is...the fastest-growing segment of the US cosmetic-surgery industry (*More*, May 1992).

Traditionally men have accessed body-building technologies as a means to sculpt and transform their bodies. Cosmetic surgery technologies aimed at men also play to stereotypes about masculinity and male sexuality. For instance, the development of pectoral implants suggests that cosmetic surgery is starting to develop technologies that imitate muscle mass in order to cater for this potential market. This trend in gendered cosmetic surgery for men is recognised in the following magazine extract:

...women aren't the only victims of stereotyping, there are quite a few men around whose strong jaws owe more to silicone implants than genes (*Mode*, October/November, 1993).

Paradoxically, discourses that normalise or reify men's bodies and male sexuality are also evident in critiques of constructions of feminine sexuality.

Iris Young's (1990b) feminist critique of the phallus as a standard against which the female breast is measured illustrates this:

A fetish is an object that stands in for the phallus - the phallus as the one and only measure and symbol of desire, the representation of sexuality. This culture fetishizes breasts. Breasts are the symbol of feminine sexuality, and *the "best" breasts are like the phallus: high, hard, pointy* (Young, 1990b:190 italics my emphasis).

Ironically Young uses a normalising discourse about the phallus in order to critique discourses and practices that normalise and fetishize women's breasts. Young's analysis of the 'male gaze' also homogenises male subjectivity and experience. According to Iris Young (1990b: 179) subjectivity is crucially constituted through relations of looking. Within this analysis Young suggests when women (re)craft their bodies in relation to conventional ideals of femininity, they are constructing themselves in relation to an anonymous, objectifying male gaze. For Young:

The gaze is masculine, and that upon which it gazes is feminine. Women are only lack, the other that shores up the phallic subject, the object that gives power and unified identity to men's looking. If women are to achieve any subjectivity it can only be through adopting this position of the male subject who takes pleasure in the objectification of women (Young, 1990b: 179).

There are two assumptions contained within Young's analysis of the 'male gaze'. Firstly she assumes that the male subject is homogeneous, and secondly that there is only one gaze and it is unilinear. When men use cosmetic surgery to reconstruct their bodies and/or (re)craft their identities they not only challenge the idea of a homogeneous male subject, they also disrupt the notion of a unified and totalizing male gaze that subjugates, oppresses and exploits a passive female object. Through cosmetic surgery men become objects of the medical gaze, and potential objects of a 'female gaze' or a 'homosexual gaze'. For whom are men who have cosmetic surgery creating images? Do men take pleasure in their own objectification? For which audience do men reconstruct their bodies?

The 'gaze' Iris Young identifies is a disciplinary technique through which 'appropriate' ways of seeing are constructed and deployed. The social conventions surrounding looking construct this gaze in relation to 'heterosexual-sociality'<sup>28</sup>. Through targeting male bodies for aesthetic correction and improvement, plastic surgeons construct female pleasure in

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<sup>28</sup> See: Smith, 1990: 191 and Du Plessis, 1992: 5-6

relation to male stereotypes of what women want, but also implicitly in relation to how women view/objectify and use men's bodies.

Problematizing gendered assumptions about the process of 'gazing' disrupts assumptions that men only 'look' while women 'do' cosmetic surgery. The following popular texts present cosmetic surgery for men as normalising discourses about men's bodies and male sexuality:

All men are not created equal. Whether it's flaccid or erect, women, given the choice, would usually choose something larger -

Dr Robert Stubbs, plastic surgeon (*The Press*, 05/11/93).

As for penis enlargement, well it's not on quite the same scale as implanted breasts but it's around. It's possible for men to gain an extra couple of centimetres lengthwise by snipping a ligament at the base of the penis - but the trade off is a shift in the angle of the penis which makes some sex positions difficult (*Mode*, October/November, 1993)

The assumptions contained in the above discourses on penis enlargement suggest that larger is better, and that a man who has an undersized penis is less adequate. It is implied that women provide the objectifying gaze, and that men who have penis enlargement are recrafting themselves for women. In the advertisement, shown in Figure 4.1, '*Men Only*', male readers are invited to have a 'totally natural' penile enlargement for 'improved confidence' and as a form of 'self improvement'. The advertisement suggests that you can have a penile enlargement and 'Enjoy Your "NEW" Life', and that through penile enlargements and penile lengthening 'Dreams **DO** Come True'<sup>29</sup>. Stereotypes about male sexuality are also present in the way plastic surgeons talk about the aesthetic 'ideal' for men. In the following extract a plastic surgeon draws a parallel between the nose and the phallus:

Though the surgical approach to rhinoplasty is the same for men and women, the aesthetic ideal is different. For many, the male nose is a phallic symbol. It is traditionally left in larger proportion to the face in the male, even when a reduction is done (Moynahan, 1988: 190).

Although men are significantly less likely to use cosmetic surgery technologies than are women, the discourses and practices surrounding an aesthetic masculine ideal deconstructs the gendered binary opposition between 'doing' and 'looking'. Like women, men also access cosmetic surgery technologies as a means to feel good about themselves and as a way to increase their self confidence:

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<sup>29</sup> Is this a linguistic play on orgasm?

The men who seek cosmetic changes want to feel better about themselves in the presence of peers, male or female, and more confident when they spy their own reflection in passing a shop window (Moynahan, 1988: 185).

Men's engagement in the discourses and practices of cosmetic surgery suggest that some men are aware of the way physical appearance is evaluated by others. That many men are self conscious about body image is also incorporated into discourses that promote the use of cosmetic surgery as enhancement of career opportunities:

...businessmen are opting for collagen implants or hair transplants to give them an edge over younger executives...The decision to go under the knife or needle, varies greatly between the sexes. He says women indulge...to increase their femininity...Men on the other hand are "generally more aggressive and interested in the workplace". Males are looking to sharpen their image... (Dr Mel Elson - *NZ Herald*, 11/8/92)

The plastic surgeon draws on generalised assumptions about why women and men use cosmetic surgery. Women use cosmetic surgery to increase their femininity while men may use cosmetic surgery as a way to remain competitive in the workplace. Plastic surgeons also present men's cosmetic surgery as a discourse of masculinity:

Some are subject to a macho image that makes them embarrassed and reluctant to admit they want help (Moynahan, 1988: 186).

...a chin that is neither too small nor too large is considered by some to be a sign of masculinity...The contour of a receding chin, which some consider to give an impression of weakness of character, may be built up with implants. An over-prominent chin that may seem to give the appearance of belligerence can be pared down. One other cosmetic change sometimes requested is the addition of a dimple in the chin, a bit of adornment greatly admired by some women and one easily achieved with the surgeon's tools (Moynahan, 1988: 191).

This plastic surgeon associates particular masculine personalities with the shape of the male chin. Changing the shape of your chin is equated with changing the way you are perceived by others. Like elective breast surgery, cosmetic chin surgery is presented as a way of recrafting identity.

Although men are less likely to access cosmetic surgery technologies are than women, men's engagement in cosmetic surgery practices offers some interesting challenges for feminists analysing cosmetic surgery. Discourses surrounding cosmetic surgery technologies that target men's bodies reproduce generalised assumptions about masculinity and male sexuality. However,

men's engagement in cosmetic surgery disrupts gendered assumptions about relations of looking and about how women and men rework their bodies.

#### 4.7 SUMMARY

In this chapter I have argued that cosmetic surgery is a contested site, fragmented by internal debates and external concerns. I have suggested that, while cosmetic surgery disrupts the assumptions about the 'natural' body, it also contains sets of discourses and practices that construct a particular narrow definition of the 'ideal' body. In questioning the constructed opposition between plastic and cosmetic surgery, I have argued that language is a crucial point of entry for understanding the way (corpo)reality is institutionalised and experienced. Through an analysis of the talk of the surgical corsetieres and the plastic surgeons, I have attempted to trace some of the ways in which ideals of femininity (and masculinity) are discursively constructed and institutionalised within medicine. Chapters Three and Four have considered how cosmetic surgery 'works'. The next chapter looks at what happens when there is a general public perception that a particular cosmetic surgery technology does not work. It focuses on the controversy over silicone breast implants.



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Figure 4.1: 'Men Only': An example of a cosmetic surgery advertisement for penile enlargement. Unsourced. (From a San Francisco Newspaper, August 1993.)

## CHAPTER FIVE

### PLEASURE AND RISK: THE AMBIGUITIES OF CONTROL

#### *Helen's Story*

*Helen sits propped up in the hospital bed, doped up with pain killers she feels tired from the anaesthetic. A white plastic drain emerges from each armpit, depositing a red discharge into a glass bottle placed on the floor at each side of the bed... The operation, described medically as a complex removal, had taken twice as long as the Plastic Surgeon predicted. During the operation the Surgeon discovered Helen's implants had not only ruptured<sup>1</sup> (the pre-operation diagnosis), but completely disintegrated. She found the tattered remnants of the outer shell of both Helen's implants had migrated and lodged firmly under her armpits. The shell under Helen's left armpit would not come out easily, the Surgeon had to rip it away from the surrounding muscle piece by piece. In order to extract the free silicone, which had merged with Helen's body tissue, the Surgeon was forced to remove all of her breast tissue - including the supporting muscles directly above the breast... Effectively Helen's breasts have been hollowed out, leaving only the skin to hang like deflated balloons down her front. Even so, the Plastic Surgeon is not confident she has removed all of the silicone. Directly after the operation Helen says she feels 'mutilated', she expresses disappointment that the Surgeon had not followed her instructions to remove her breasts entirely, she had not wanted to be left with these... (June 1993).*

Fourteen years after receiving Dow-Corning silicone-gel implants free through her medical insurance in Australia, Helen paid over three thousand dollars to have them removed in New Zealand. Helen's story is a worst case scenario, a poor outcome in the silicone-gel implant controversy. She is one of over three hundred New Zealand and two thousand Australian women<sup>2</sup> seeking damages from the American manufacturers of silicone-gel implants.

<sup>1</sup>When an implant ruptures the silicone-gel is usually contained inside the hard capsule that forms around the implant after it is inserted. In Helen's case the shell of both implants and the silicone-gel had migrated through the scar capsules and spread throughout her body.

<sup>2</sup> Slater and Gordon: *Breast Implant Update*, September 1992.

In Chapter Four<sup>3</sup> I suggested that the 'scientific', ideological, and economic support for cosmetic surgery has powerful cultural backing. An analysis of the discursive practices surrounding the silicone-gel breast implant debate provides an insight into the nature of this support. The silicone-gel breast implant controversy illustrates how the body is always positioned within a network of institutional structures that regulate individuals through technologies of surveillance and examination. In particular, medical debates, such as that relating to silicone-gel implants, focus attention on the way institutions mediate the private relationship between a doctor, patient and their environment. These debates simultaneously challenge and reinforce the dominant status of medical knowledge. According to Jana Sawicki (1991), the authoritative position of modern medicine emerged gradually as a result of key debates throughout its history. Therefore it is important to focus not only on the dominant discourses and practices of the medical profession, but also on the moments of resistance that challenge and modify these practices (Sawicki, 1991: 81).

The silicone implant controversy can be analysed as a key moment in the development of dominant discourses within the plastic and cosmetic surgery field. In describing the recent history of the silicone-gel implant debate in New Zealand, my interest is not only in the dominant medical and technological discourses and practices of cosmetic surgery, but also in the micro-practices and strategies of resistance that are continuing to challenge and transform these discursive practices.

The silicone-gel breast implant controversy has not only touched the lives of the individual women involved, but has also been debated within the state, medical and legal spheres of society. Currently the protocol surrounding the availability of silicone-gel implants in New Zealand can be seen as the outcome of a complex set of discursive arrangements between the Department of Health, the women's health movement and medical and legal interests. At the abstract level, the legitimacy of each of these discursive positions can be located within particular sets of scientific, economic or feminist understandings. At the concrete everyday level, they can be seen as representing the interests of individual women and men, the plastic and cosmetic surgeons, insurance companies, manufacturers and governmental agencies. The following section provides a case study of the 'Natural Y' and examines the historical origins of the American Silicone-gel implant controversy and its relevance in the New Zealand context.

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<sup>3</sup> See Section 4.2.

## 5.1 THE FDA AND THE CONTROVERSIAL HISTORY OF SILICONE-GEL IMPLANTS

Silicone-gel breast implants were developed in the early 1960s, and became available for general sale in 1964<sup>4</sup>. Their use has never been approved by the American Federal Drug and Food Administration (FDA). This situation emerged because of differences in the FDA's policies regarding the regulation of drugs and those regarding the regulation of medical devices. Prior to 1976 manufacturers of medical devices were self-policing in assuring the safety and efficacy of their products. In 1976 a congressional amendment to the Federal Food, Drug and Cosmetic Act, enabled the FDA to regulate the use of medical devices, including breast implants (*Mother Jones*, 1992: 28). At that time it was assumed that medical devices already on the market were safe because they had been in use for some time (*FDA Backgrounder*, Sept. 1991). On May 28 1976 this assumption, termed 'the Grandfather clause' within the legislation, became law.

In 1976 breast implants were automatically registered as a Class III device, which meant they fell under the 'grandfather clause' within the legislation. Initial questions about the safety and efficacy of breast implants were raised in a 1980 television documentary produced by the Canadian Broadcasting Corporation. The programme focused on the problem of capsular contracture, or hardening caused by scar tissue forming around the silicone breast implant, and detailed the concerns of a small group of plastic surgeons who were calling for a moratorium on the use of implants (*Mother Jones*, 1992: 26).

In 1982 the FDA sought a review of silicone breast implants. The review produced a proposal to change the status of breast implants, downgrading them from a class III device to a class II medical device. The change of status would require the manufacturers of breast implants to supply development protocol data to the FDA in order to gain pre-market approval to distribute the devices (Krause, 1993: 1). Following pressure from the American plastic surgeons and the manufacturers, the FDA declined to take strong regulatory action and 'only proposed that implants be placed in a category indicating that there was insufficient evidence to provide reasonable assurance of their safety and

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<sup>4</sup> 'Silicone implants: Booming Busts', *The Economist*, 12/01/91: 81

efficacy' (*Mother Jones*, 1992: 28). Between 1984 and 1987 the FDA received 1800 medical device problem reports on breast implants (Barram, 1992: 11)<sup>5</sup>.

At the present time the development protocol for silicone-gel breast implants does not meet required FDA standards for a medical device intended for internal human use. Since the development protocol of any drug, medical device or surgical procedure originating from the 1960s would not pass medical, ethical and scientific standards set in the 1990s, this fact in itself is not particularly disturbing or unusual. However, the FDA did not take strong regulatory action against the implant manufacturers when safety and efficacy problems first came to light in 1982/83. This decision was influenced by the implant manufacturers and the plastic surgeons who either ignored or covered up problems with the development and use of the device (*Mother Jones*, 1992: 28; Dunleavy, 1992: 1-2). An examination of the genealogy of the 'Natural Y' or 'Meme' breast implant device provides a stark illustration of this process.

## 5.2 CASE STUDY - 'THE NATURAL Y'

Polyurethane foam coated silicone-gel breast implants were first patented in 1968-71 by Dr. John Pangman<sup>6</sup>. Initially they were manufactured and distributed by Heyer Schulte under the brand-name 'Natural Y'. In 1978 Heyer Schulte discontinued manufacturing the implants following reports of implant failure and concerns about the internal medical use of untested polyurethane foam. The manufacturing and distribution rights were sold to Hal Markham who contracted Cox Uphoff to manufacture the same implants using component parts supplied by Heyer Schulte. The implants were marketed and distributed by Natural Y Surgical Specialties Inc.. In 1981 Markham founded a new manufacturing company, Aesthetech Corp., which took over production of the Natural Y. Markham's company also developed and manufactured a range of generic breast implants including the 'Meme', 'Vogue', 'Replicon' and the 'Optimam'. The specifications and materials used in the manufacture of these implants replicated the original Natural Y produced by Heyer Schulte (*Mother Jones*, 1992: 28-29; Dunleavy, 1992: 1-2).

During 1987 Aesthetech and Natural Y Surgical Specialties Inc. were absorbed into the Cooper Companies Inc., in the same year several American women filed personal injury suits against Natural Y, Coopers Surgical and Aesthetech.

<sup>5</sup> Barram, Mary: Breast Implant Information Kit. Women's Health Centre, Brisbane. March 1992.

<sup>6</sup> Prior to this silicone-gel breast implants were produced without the polyurethane-foam coating.

In a deal that was finalised on December 14, 1988, Coopers on-sold the rights to produce and distribute the implants to Surgitek, a subsidiary of Bristol Myers Squibb Co. (Dunleavy, 1992: 2)<sup>7</sup>.

It appears that the manufacturing and distributions rights relating to the Natural Y were sold each time problems emerged with the implant and its generic descendants. Successive companies either ignored serious flaws in the development protocol for the implants or reinterpreted experimental results in order to smooth over significant gaps in the data. For example, during the time the 'Meme' was produced by Coopers Surgical the company used industrial grade polyurethane foam to cover the implants. The foam was not tested in-vitro and the chemical composition of this foam was never analysed (Dunleavy, 1992: 3; *Mother Jones*, 1992: 29). In America the following implant manufacturers have had implant product liability claims filed against them: Dow Corning, Surgitek, McGhan, Mentor and Heyer Schulte<sup>8</sup>. All of these companies contributed to the seven billion dollar out-of-court settlement for all claimants announced in September 1993.

### 5.3 THE RECENT HISTORY OF THE DEBATE

One of the first major newspaper articles to expose significant scientific and medical concerns about the safety of silicone-gel breast implants appeared in the *Montreal Gazette* in January 1989<sup>9</sup>. In April 1991 the FDA released a report containing evidence from animal studies that indicated silicone-gel breast implants released TDA, a toxic substance and suspected human carcinogen, *in vitro* (*Mother Jones*, 1992: 26). At the same time a group of Canadian doctors published a journal article detailing the presence of TDA in the urine of a patient with polyurethane-coated breast implants (Dunleavy, 1992: 3)<sup>10</sup>. Following the release of the FDA report Surgitek withdrew their implants from the market and in September 1991, Bristol Myers Squibb closed its Surgitek plastic surgery unit (*Mother Jones*, 1992: 26).

how many  
books?

<sup>7</sup> In *Medical/Legal Aspects of Breast Implants*, Volume 1, No. 1/December 1992.

<sup>8</sup> Women sue over implants 17/09/91.

<sup>9</sup> Nicholas Reguish, the reporter who wrote the article in the *Montreal Gazette*, and is credited with exposing the silicone-gel breast implant scandal, also co-wrote the 1980 Canadian television documentary.

<sup>10</sup> See Chan et.al. Detection of Tolunediamines in the Urine of a Patient with Polyurethane-Covered Breast Implants, in *Clinical Chemistry*, Vol. 37, No 5, 1991.

On April 10 1991, the FDA issued a mandatory directive requiring manufacturers of silicone-gel filled breast implants to submit data demonstrating their safety and effectiveness. In a preliminary analysis of the data from a total of seven companies, the FDA concluded that three manufacturers had submitted information that was incomplete or insufficient for the purpose of conducting a full-scale review to determine the safety and efficacy of the implants. Those manufacturers whose data were initially deemed insufficient were given the following immediate options: conducting scientific studies to provide the required data, withdrawing their products from the market or appealing the FDA's decision - in which case their products would remain on the market subject to the appeal. Of the four remaining companies, whose data were initially acceptable for the purpose of conducting a full-scale review, the FDA advised 'there were deficiencies in the data that may prevent the FDA from answering important safety and effectiveness questions' (*FDA Backgrounder*, Sept., 1991). Effectively by the July 9 1991 deadline, none of the seven manufacturers of silicone-gel implants had supplied satisfactory information to the FDA.

#### 5.4 CONTRADICTION AND SIMILARITY IN THE DISCURSIVE PRACTICES OF THE FDA

The information available from the FDA to the public in 1991 reflected the divergent interests of the various groups contributing to the debate, as well as considerable ambiguity in the way women's bodies were viewed. The following extracts can be read as simultaneously contradictory and complementary:

The exact life span of an implant is unknown and varies from woman to woman. Implants last for many years in some women and have to be replaced more frequently in others (*FDA Backgrounder*, Sept., 1991).

The scant information that is currently available on "possible risks" does not warrant removing the implants, especially considering that any surgical procedure carries a risk of its own (*FDA Backgrounder*, Sept., 1991).

In the first extract the possibility of a woman requiring more than one set of implants during her lifetime is discussed unproblematically. In the second extract removal of an implant is not recommended due to the known risks involved in any surgical procedure. According to the information available from the FDA having a defective or replacement implant might be more acceptable than the risk of (additional) surgery. The subtextual messages

contained in both of these extracts contain an underlying assumption that women should have the choice to have implants in order to be adequately breasted; the known risks involved with having a potentially defective implant or a replacement implant are more acceptable than no implant at all.

In New Zealand the Health Department delayed responding to the initial report issued by the FDA (in April 1991) until January 1992 when it placed a 45 day moratorium on the use of silicone-gel implants pending a decision by the FDA (*NZ Doctor*, 23/01/92). Originally due in January 1992, the FDA findings were finally released in April 1992, concluding there was a 'lack of evidence about associated health risks' (*Evening Post*, 15/07/92). In July 1992 the Health Department lifted its ban on silicone-gel filled breast implants (*The Press*, 16/07/92).

## 5.5 PRINT MEDIA COVERAGE OF THE CONTROVERSY IN NEW ZEALAND

In Chapter One<sup>11</sup> I suggested it was possible to explore the dominant ideological foundations of cosmetic surgery through an analysis of cosmetic surgery texts. The messages contained within oral and written texts reflect linguistic processes that privilege particular meanings and definitions of cosmetic surgery. The way the New Zealand print media represented the silicone-gel breast implant controversy, during 1992 and 1993, simultaneously influenced and illustrated societal attitudes towards this form of cosmetic surgery. From April 1991 until July 1994, I collected a sample of approximately sixty news items on silicone-gel breast implants. The clippings included articles, features, advertisements and news items that appeared in New Zealand newspapers and women's magazines over this time period<sup>12</sup>. An overall examination of print media accounts of the silicone-gel breast implant controversy indicates that women were constructed as the 'unwitting' 'victims'. Most of the 'blame' was directed towards the American breast implant manufacturers. The New Zealand Department of Health and the New Zealand plastic surgeons generally escaped responsibility.

Information relating to problems with the silicone-gel breast implants first became available in New Zealand through reports in magazines published in

<sup>11</sup> See Section 1.2.

<sup>12</sup> See Appendix Two



Britain and the United States. The first article appeared in *The Economist* in January 1991. Titled, 'Silicone implants: Booming Busts'<sup>13</sup>, the article provides details of a congressional hearing on silicone-gel breast implants held in December 1990. In April 1991, the same month as the FDA placed a moratorium on the use of silicone-gel implants, an article appeared in *Time* magazine titled 'Time Bombs in the Breast?'<sup>14</sup>. The article provides details of a 'leaked' FDA report indicating that 'the polyurethane foam-coating surrounding the 'Meme' and 'Replicon' brands of implants could break down in the body into a substance called...TDA'<sup>15</sup>. The first article I have been able to identify in a New Zealand women's magazine appeared in May 1991. Titled 'Julie Breen's silent hell'<sup>16</sup> the article documented the experiences of an Australian woman who described how her breast implants ruptured, leaking silicone into her chest and abdomen. On June 17 1991 a small item on breast implants appeared in the *New Zealand Doctor*. The article described the presence of TDA, a 'cancer-causing chemical in the milk of a woman who had breast implants covered with polyurethane foam'<sup>17</sup>. In September 1991 *The Press* ran an article titled 'Women sue over breast implants'<sup>18</sup>. Originating from America, the article reported that two law suits, representing eight Texas women, had been filed against several manufacturers of silicone implants. Named in the suit were Dow Corning Corp. and Bristol Myers Squibb Co.

In April 1992 the first article indicating that New Zealand women could also be affected by the American implant controversy appeared in the *New Zealand Doctor*<sup>19</sup>. It reported that eleven New Zealand women were preparing to sue American implant manufacturers. They had joined a group of approximately 200 Australian and 2500 American women who had already reported problems with their implants. By July 1992 the number of New Zealand women seeking compensation had risen to 23<sup>20</sup> and by the first 1994 registration deadline the final number exceeded 200<sup>21</sup>. Appendix two provides a chronological record of articles about the silicone-gel implant controversy within the New Zealand print media. The most active periods for publicity about implants were in July and September of 1992. The purpose of this publicity was three fold: First, to

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<sup>13</sup> *The Economist*, 12/01/91

<sup>14</sup> *Time*, 29/04/91

<sup>15</sup> *Ibid.*

<sup>16</sup> *New Idea*, 04/05/91 pp. 32-33.

<sup>17</sup> 'Breast Implants Carcinogenic?' *New Zealand Doctor*, 17/07/91.

<sup>18</sup> *The Press*, 17/09/91.

<sup>19</sup> 'NZ women prepare to sue over silicone'. *New Zealand Doctor*, 16/04/92.

<sup>20</sup> 'Silicone implants - A case to answer?' *NZWW*, 20/07/92.

<sup>21</sup> Initially women were advised to register by June 17 1994 (*The Christchurch Mail*, 16/06/94), the current deadline is 1/12/94 (Department of Health advertisement in *The Press*, 09/06/94).

inform women who had breast implants about potential problems, second to warn women who were contemplating having implants, and third to register New Zealand women who wanted to seek damages from the American manufacturers.

The major publicity generators of this publicity were the Health Department acting on information from the FDA, the Wellington lawyer representing New Zealand claimants, the plastic surgeons and the women themselves. At the height of the publicity there was widespread confusion surrounding information about silicone-gel breast implants. The confusion was created by publicity which reflected the different agendas of a number of interest groups. The following print media titles and extracts illustrate the debate about 'safe' and 'unsafe' breast implants within and between the medical profession and medical technology discourses:

### SAFE

Local surgeons are certain of breast implant safety (*NZ Doctor*, 23/01/92)

...the British Ministry of Health...(recently)...declared that they considered breast implants safe and that in the UK there was no evidence to preclude their continued use - 'Breast Implants, Furore and Facts' (*Glaze*, summer 92/93)

Reassurance for women with implant fears (*GP Weekly*, 02/09/92)

Evidence casts doubt on implant-illness link (*The Press*, 17/06/94)

### UNSAFE

Breast implants carcinogenic? (*NZ Doctor*, 17/06/91)

Silicone triggers specific immune reactions - study (*GP Weekly International*, 13/09/92)

Research casts doubt on implants (*The Dominion*, 16/09/92)

Breast implants linked to new diseases (*The Press*, 11/02/93)

Several articles appearing in the print media disputed the claims that women were experiencing problems with implants. In 'Breast Implants Furore and Facts'<sup>22</sup>, 'Breast Implants - the pros and cons'<sup>23</sup> and 'Breast implants - the facts - not media hype'<sup>24</sup>; plastic surgeons suggested that health risks, such as arthritis and auto-immune disorders, which had been linked to women with breast implants, were no different to the risks experienced by women in the general population. At the same time articles also appeared in conservative in-house

<sup>22</sup> *Glaze*, Summer 92/93 pp. 31/32.

<sup>23</sup> By Dr. Gregory D. Taylor in *HealthCare*, March, 1994 (*Amcal Chemists Magazine*) pp. 30-32.

<sup>24</sup> *Glaze*, Summer 92/93 p 47.

medical periodicals that suggested breast implants could be carcinogenic<sup>25</sup> and that 'silicone triggers specific immune reactions'<sup>26</sup>. The lawyer acting on behalf of the women was calling for a ban on implants<sup>27</sup> and women with implants were publicising their unhappy experiences<sup>28</sup>.

Newspapers and magazines also contributed to the uncertainty of those who had received implants by using sensationalism and fear as a marketing strategy in order to capture the largest possible audience. A major theme was that breast implants were at war with the body. The titles of several notable articles on breast implants variously described them as 'time bombs in the breast'<sup>29</sup>, 'the enemy inside'<sup>30</sup>, and 'toxic breasts'<sup>31</sup>. Breast implants posed a 'threat... to health' and 'destroyed life'<sup>32</sup>. Headlines used high impact words like 'fear', 'tormented', 'disease', and 'danger' to grab the readers' attention. While several articles used names and photographs to personalise the experiences of women who had problems with their implants, the captions given to these articles also invoked images of intolerable suffering and pain:

#### VICTIMS...

Jessica's implant horror (*New Idea*, 04/05/91)

Silicone Nightmare: Breast implants were to end years of problems for Joy Bradey, but instead they nearly destroyed her life and still pose a threat to her health (*Woman's Day*, 17/11/92)

Julie Breen's silent hell (*New Idea*, 19/06/93)

Alana's implant shock (*New Idea*, 26/07/94)

Implant woman fears for health (*North Shore Advertiser*, 28/07/92)

Implant's worry Nelson woman (*Nelson Evening Mail*, 23/07/92)

The headlines were directed at creating a sense of drama or urgency around the issues. The discursive imagery also implied a form of social distancing and a way of constructing the women as 'other' ('implant woman', 'silent hell'). While women were the 'unwitting' victims of unsafe medical technologies, the implant manufacturers were represented as the main villains in the debate. Within the

<sup>25</sup> 'Breast Implants Carcinogenic?', *New Zealand Doctor*, 17/16/91.

<sup>26</sup> 'Silicone triggers specific immune reactions - study', *GP Weekly International*, 09/13/92.

<sup>27</sup> 'Lawyer wants implants banned', *Oamaru Mail*, 16/04/92.

<sup>28</sup> 'Implants worry Nelson Woman', in *Nelson Evening Mail*, 23/07/92. 'Implant woman fears for health', in *North Shore Advertiser*, 28/07/92.

<sup>29</sup> 'Time Bombs in the Breast?' *Time*, 29/04/91.

<sup>30</sup> 'The Enemy Inside', *More*, March 1994.

<sup>31</sup> 'Toxic Breasts', *Mother Jones*, January/February 1992.

<sup>32</sup> 'Silicone Nightmare', *Woman's Day*, 17/11/92.

popular press it was widely accepted that New Zealand women were suing the American manufacturers of silicone-gel breast implants for misleading the public over safety and efficacy issues. The majority of articles about breast implant litigation pursued this theme:

### ...AND VILLAINS

...(the) manufacturers were aware that no satisfactory evidence of product safety existed at the time (they) began selling and advertising their defective breast implants... ('Women sue over breast implants' (*The Press*, 17/09/91))

The American manufacturer led her and other women around the world to believe that implants were safe - Joy ('Silicone Nightmare', *Woman's Day*, 17/11/92)

"I do blame the manufacturers who made extravagant claims that can't be substantiated" - Anon ('Implant woman fears for health', *North Shore Advertiser*, 28/07/92)

While some news items referred briefly to research evidence of implant failure,<sup>33</sup> no comprehensive investigative articles about the controversial American history of breast implants appeared in the New Zealand print media. In one article a plastic surgeon suggested criticisms directed at the FDA regarding the safety of a Dow Corning product were 'largely historical'<sup>34</sup>, but there was no elaboration on this theme. Instead the medical profession generally represented complications with breast implants as either a problem of poor surgical technique or an individual problem between the surgeon and client:

### DOCTOR RESPONSIBILITY

Most of the 'horror' stories seen in the media are...about inappropriate and ineffectual surgical management of this problem, (of capsular contracture) resulting in deformity, pain and disability - Dr. Gregory D Taylor, ('breast implants- the pros and cons', *HealthCare*, 03/94)

...it is the doctor's responsibility, 'not the FDA's, not the New Zealand government's, not anyone else, to discuss with the patient the side effects we know about' - Dr. Mel Elson<sup>35</sup>

Furthermore, women were responsible for finding out the correct information so they could make 'informed choices':

<sup>33</sup> See 'Keeping abreast of the dangers', by Sandra Coney, in *The Dominion Sunday Times*, 12/07/92, and 'Women sue over breast implants', in *The Press*, 17/09/91.

<sup>34</sup> 'Reassurance for women with implant fears', *GP Weekly News*, 02/09/92.

<sup>35</sup> 'US doctors failed patients over silicone implants', *NZ General Practice*, 05/08/92.

## CLIENT RESPONSIBILITY

Patients have a responsibility to themselves to find the answers (to questions relating to potential problems)<sup>36</sup>

Two articles suggested some plastic surgeons 'failed' to adequately inform their patients of the potential dangers:

US doctors failed patients over silicone implants (*NZ General Practice*, 05/08/92)

...some plastic surgeons had "abdicated their responsibility by not informing patients of known risks..." - Michael Okkerse, Lawyer (*Gisborne Herald*, 09/07/92)

The New Zealand plastic surgeons defended their position by suggesting they were unaware of the problems, or that women were informed of the risks:

Plastic and Reconstructive Surgeons Association head Dr. Max Lovie...has previously said that surgeons were not aware the devices might rupture..."Up until about a year ago the belief was they would last indefinitely" ('Call to show fact sheet on gel implants', *Gisborne Herald*, 09/07/92)

I would like to think that patients who have had the operation in the past were aware that capsular formation was a well-known problem and chose to accept the risk - Dr. Gregory D Taylor, ('breast implants - the pros and cons', *HealthCare*, 03/94)

This notion of a knowledgeable consumer who was able to make 'informed choices' was eventually taken up by the Department of Health as a solution to evidence of problems with breast implants (issues of 'informed consent' and 'choice' are problematised later in this chapter). Several newspaper articles referred to the role of the Department of Health in the controversy. The Health Department's position on implants was widely reported in the media, the following extract is a typical example:

At present the Health Department discourages use of silicone implants but does not ban them ('Silicone review call', *Bay of Plenty Times*, 16/09/92)

The New Zealand Health Department eventually settled on a middle-ground position on silicone-gel breast implants. This stance was criticised by women's health activists. Two articles suggested Health Department inaction over breast implants was 'scandalous'<sup>37</sup> 'completely unethical'<sup>38</sup> and 'irresponsible':

<sup>36</sup> Ibid.

<sup>37</sup> Lynda Williams, Fertility Action, in 'Call to show fact sheet on gel implants', *Gisborne Herald* 09/07/92.

<sup>38</sup> Ibid.

It's irresponsible for the Department of Health to say they're leaving it up to women to decide for themselves about implants. Isn't the department meant to protect public health? - Sandra Coney ('Keeping abreast of the dangers', *Dominion Sunday Times*, 12/07/92)

Similarly, those people directly involved in the silicone breast implant controversy wanted stronger regulatory action from the Department of Health:

Lawyer wants implants banned (*Oamaru Mail*, 16/09/92)

'My biggest worry is why the Health Department can't come out with a definite statement, like whether or not these implants are safe' - Liz ('Silicone Implants: A Case To Answer?' *NZWW*, 20/07/92)

The linking of breast implants to restoration of, or approximation to, ideals of femininity was apparent in several news items. In the following extracts several plastic surgeons suggest restricted availability of silicone implants would limit the options available to women:

#### BREAST IMPLANTS AND FEMININITY

...for those women who have had a mastectomy,...have been involved in some sort of accident or just unfortunate to be born with under developed breasts, it would appear that they were losing the opportunity to correct their disfigurement... - Dr. Gregory Taylor ('Breast Implants - the facts - not media hype', *Glaze*, Summer 92/93)

A majority of women...need implants because of a distortion, cancer, or if their breasts are underdeveloped - Dr. Crabb ('Implant ban lifted', *Northshore Times Advertiser*, 14/07/92)

...silicone may have been unjustly damned, reducing women's options and frightening those who already have implants ('Implant scare limits treatment', *NZ Doctor*, 03/02/94)

Another theme articulated through the print media by plastic surgeons was that women were unnecessarily scared by the publicity:

#### 'SCARE MONGERING'

We should not be scare mongering over a procedure that has been used for 20 years- Surgeon, Robert Phipps ('Implant scare limits treatment', *NZ Doctor*, 03/02/94)

'They (the FDA) inadvertently frightened a large number of women for no reason. Women thought they were walking around with time-bombs in their chest' ('US doctors failed patients over silicone implants', *NZ General Practice*, 05/08/92)

The effect of an unbalanced and sensationalised media campaign is that many of these women have been unnecessarily alarmed...A more balanced account of the facts may well have avoided much unnecessary fear and anxiety among those who have good results from breast augmentation - Dr. Gregory D Taylor (breast implants - the pros and the cons, *HealthCare*, 03/94)

The implicit message in the above extracts is that problems with silicone-gel breast implants were not based on scientific evidence, but were created by 'media hype'<sup>39</sup> ('The FDA was set up as a scientific organisation but instead of science, we had a media event'<sup>40</sup>). For the plastic surgeons, problems with silicone-gel implants were sensationalised and over-emphasized by the media, and this had caused unnecessary concern to women who were previously happy with their implants<sup>41</sup>.

The plastic surgeons were concerned that their clients were 'inadvertently frightened' or 'unnecessarily alarmed' by the publicity. However, at another level their statements can be interpreted as calling into dispute the anecdotal evidence of women who felt their implants were causing them health problems. This agenda was often explicit:

...while leakage or rupture is possible and free silicone can pass into the lymph nodes or liver there is no clear evidence that it is harmful - Dr. John de Geus, plastic surgeon<sup>42</sup>

Most disturbing are suggestions that 'silicone-gel disease' exists and may present as several forms of arthritis and immune disorder - Dr. Gregory D. Taylor<sup>43</sup>

Two articles suggested that in one case the California courts had been misled by 'a false association...between the presence of implants and the presence of arthritis'<sup>44</sup>:

'The case was based on an article written some years ago which said five or six women developed arthritis which was thought to be an auto-immune reaction related to gel filled implants... we don't believe that the number is statistically significant compared to the thousands of women who have implants...' - Dr. J de Geus<sup>45</sup>

<sup>39</sup> 'Breast implants - the facts - not media hype', *Glaze*, Summer, 92/93.

<sup>40</sup> 'Reassurance for women with implant fears', Dr David Crabb, plastic surgeon, *GP weekly News*, 02/09/92.

<sup>41</sup> 'Breast implants - the facts - not the media hype', *Glaze*, Summer, 92/93.

<sup>42</sup> 'Local surgeons are certain of breast implant safety', *New Zealand Doctor*, 23/01/93.

<sup>43</sup> 'breast implants - the pros and cons' (*HealthCare*, 03/94). Other articles also mentioned there was no clinical evidence linking silicone gel implants to the development of arthritis or auto immune diseases. These articles included 'Breast Implants - Furore and Facts' (*Glaze*, summer 1992), 'Implant ban lifted' (*North Shore Times Advertiser*, 14/07/92), and 'Breast implants - the facts - not media hype' (*Glaze*, summer 92/93).

<sup>44</sup> 'Breast implant - Furore and Facts', *Glaze*, Summer 92/93.

<sup>45</sup> 'Local surgeons are certain of breast implant safety', *NZ Doctor*, 23/01/93.

A minor theme linked problems with silicone implants to women's reproductive choices. Several articles reported on the presence of either TDA or silicone antibodies in the breast milk of women who had silicone implants:

### BREAST IMPLANTS AND MOTHERING

Silicone Baby: A tormented mum fears she may have poisoned her young son (*Woman's Day*, 17/08/93)

A cancer-causing chemical (TDA) has been found in the milk of a woman who had breast implants covered with polyurethane foam... (*New Zealand Doctor*, 17/07/91)

The presence of silicone and silicone gel in breast milk has not been demonstrated (breast implants - the pros and cons, *HealthCare*, 03/94)

While some members of the medical profession disputed evidence that the presence of silicone antibodies in breast milk was potentially harmful, the implicit message conveyed in these statements suggested that women who had silicone-gel breast implants not only put their own health at risk, but also the health of any future children.

Between 1991 and 1994, discourses within the New Zealand print media suggested implants were both safe and unsafe. Internationally, implants were banned in Australia and America, unbanned in Britain and an initial ban lifted in New Zealand<sup>46</sup>. Some doctors claimed there was no link between illness and silicone gel; some research results indicated there was a potential link. A number of New Zealand doctors publicly assured women that their implants were safe; the FDA said that the safety and efficacy of implants could not be assured. The Department of Health did not endorse breast implants, but provided information to women directed at ensuring that women could make informed decisions. Plastic surgeons were responsible for making sure clients had the right information and accepted the 'risks'; clients were responsible for finding out the answers. Some doctors said they were not aware of problems with the implants; and suggested women were informed of the risks. Anecdotal evidence from women who had silicone-gel breast implants pointed towards significant problems with these medical devices. Anecdotal evidence was often disputed by a number of plastic surgeons who used lack of scientific evidence

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<sup>46</sup> At the time of writing internationally implants are severely restricted in Australia and America and available in New Zealand and Britain.



or inconclusive research results to call into question the findings of the US courts.

An analysis of the dominant discourses in the New Zealand print media on silicone-gel breast implants focuses attention on the way professional groups were able to monopolize print media coverage of the controversy. Many plastic surgeons were not only concerned with reassuring women who had silicone implants, they also concentrated on damage control and defending their professional integrity. The lawyer representing the women 'drip fed' the media with case histories, new information about litigation developments and research evidence that supported his clients' experiences. This strategy meant that within the press a high level of concern over the safety of breast implants was maintained over a long period of time. Within the popular press individual women were portrayed as breast implant 'victims' and their breast augmentations as examples of 'bad' medical intervention. Silicone-gel breast implants were a threat to health. Media emphasis on the risks meant women with implants, who had no adverse symptoms, were also targeted as potential victims. Discourses in the print media reflected the symbolic construction of breasts as icons of femininity<sup>47</sup> and as synonymous with motherhood.

The contradictory discourses and media sensationalism not only created a climate of confusion and panic among women who had breast implants, but also made some women reluctant to seek information about their silicone-gel implants:

Two years ago my breasts started to shrink, I had heard bits and pieces about the problems coming to light with silicone breast implants, but I had avoided the publicity as much as I could. I didn't want to know about it. I was afraid of what could be happening inside my body (Helen, June 1993).

The process of disseminating information about the risks of having breast implants to women acted as a barrier to Helen actively seeking information for herself<sup>48</sup>.

<sup>47</sup> See Chapter One, Section 1.2, for a discussion of breasts as icons of femininity.

<sup>48</sup> I think perhaps this has important implications for media campaigns that use fear as a way to target groups considered 'at risk', for example HIV advertising and the current 'dem bones' campaign which targets women at risk from osteoporosis.

## 5.6 THE PPRESENT SITUATION

It is estimated that somewhere between two hundred<sup>49</sup> and one thousand<sup>50</sup> women undergo breast augmentation in New Zealand each year, and that over five thousand women have had this operation since 1965<sup>51</sup>. In the United States silicone breast implants are currently restricted to women who have had mastectomies, and any woman who agrees to participate in clinical trials and is therefore prepared to submit herself to the disciplinary technologies of medical surveillance and examination. The FDA ruling means that in future women who receive silicone breast implants will continue to be objects and subjects of medical intervention. In Britain silicone-gel breast implants are declared to be 'legal' and 'safe'<sup>52</sup>, while in Australia silicone-gel implants are 'illegal'<sup>53</sup> and available only for breast reconstruction following mastectomy<sup>54</sup>. This situation has meant a small number of Australian women are now coming to New Zealand to have implants for cosmetic reasons<sup>55</sup>.

Currently silicone-gel breast 'implants are discouraged in New Zealand but not banned' (*The Press*, 22/04/93). The Health Department 'did not "endorse" breast implant surgery' but has announced that 'women should decide for themselves' (*The Press*, 16/07/92). Strategies for discouraging women from receiving silicone-gel implants are based on the inter-related, but sometimes contradictory discourses of 'choice' and 'informed consent'. Initially the Health Department required that 'plastic surgeons must ...inform women of the risks involved with breast implants and encourage them to enrol on a register so they can be kept up to date with information' (*The Press*, 16/07/92). In the following conversation the plastic surgeon interviewed lists some of the conditions under which silicone-gel implants are currently available in New Zealand:

It has really been determined by the Health Department,...silicone-gel implants can still be used for breast reconstruction, but the patients have to be informed as to the advantages and disadvantages of having a silicone-gel implant put in... (Plastic Surgeon 1: 14/07/93).

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<sup>49</sup> *The Press*, 11/02/93.

<sup>50</sup> *NZ Doctor*, 23/01/92.

<sup>51</sup> 'Breast Implants - the pros and the cons', *HealthCare*, March, 1994.

<sup>52</sup> 'Look Me in the Eyes - and tell me they're safe', *The Times Magazine*, 07/05/94.

<sup>53</sup> *Ibid.*

<sup>54</sup> *Breast Implant Information Kit*. Mary Barram (ed.). Women's Health Centre, Brisbane. March 1992.

<sup>55</sup> One of the plastic surgeons I interviewed said he was now performing a small number of breast augmentations on Australian women because of the restricted availability of implants in Australia 22/04/94.

The 'Implants Containing Silicone-gel' register was developed by the Department of Health Therapeutics Section and released for public use in November 1992. The register is administered by the plastic surgeons and is officially an opt-on register (i.e. it has not been made a compulsory register by the Department of Health). However at the present time the plastic surgeons who are members of the New Zealand Foundation for Cosmetic and Plastic Surgery, require a prospective cosmetic surgery client to sign the register before a breast implant operation, so the information booklet currently operates as a consent form and unofficially as a compulsory register. In the following conversation one of the plastic surgeons interviewed discusses the controversy and describes how he negotiates the signing of the register with a prospective client:

You have to go through...the reasons why it has been in the media, what there may be coming out and the things we do not know about yet. Then they have to know that you are allowed to use gel, if that is what they want, and that still produces the best result. Then they have to be prepared to come back on a decent annual basis, be on this register and be prepared in the future that there may be information that shows that they should not have them in. At this stage I cannot see that, but it may come of course (Plastic Surgeon 3: 22/04/94).

This plastic surgeon indicates that he expects the women to enrol on the register and to agree to return annually for ongoing care as a pre-requisite to receiving a breast implant operation. The following section considers some of the issues involved in registering a targeted population.

## 5.7 WHAT IS A REGISTER?<sup>56</sup>

In this instance a register must be understood as a management tool for the organisation and regulation of particular social practices. In Foucauldian terms it can be seen as a modern technology of power through which a constructed medical gaze is able to penetrate and organise the population<sup>57</sup>. The Implants Containing Silicone-gel (ICS) register is one of two medical registers to have been implemented in New Zealand in recent years, the other being the Cervical Screening Inquiry (CIS) register. Both of these registers developed out of medical scandals involving women's bodies. Although there are similarities in the origins of these registers they are organised and maintained in

<sup>56</sup>Austrin, Terry (1993). This discussion draws on an analysis of the Cervical Screening Register presented by Terry Austrin in a seminar on 'Registering Consent: The Politics of Cervical Cancer'. 01/10/93. Sociology Dept. University of Canterbury, NZ.

<sup>57</sup> Ibid.

fundamentally different ways. The cervical screening register is administered by the Department of Health with the co-operation of the health professionals, while the implants containing silicone-gel register is administered by the plastic surgeons with the co-operation of the Department of Health.

In New Zealand, the cervical cancer inquiry and the silicone-gel implant controversy have been symbolic events, representing a betrayal of trust and a denial of information about the implications of medical procedures for those on whom these procedures had been performed. Both registers were developed in order to maintain public confidence in health care delivery standards. However, at a fundamental level the registers situate formal consent in a problematic relationship with trust. Within medicine trust is fundamental to the continuance of medical authority and the provision of medical services. Betrayal of trust is generally seen as a private trouble between a doctor and his or her patient or client. For example, patient confidentiality is frequently used by the medical profession to prevent individual cases from being discussed in public. This practice usually provides protection for both the patient and the health practitioner. However when betrayal of trust becomes a public issue, as in the Cartwright Inquiry and the silicone-gel breast implant debate, collective problems of trust have to be (re)negotiated. The two New Zealand cases suggest that this (re)negotiation involves a process of formal consent.

## 5.8 PROTECTION OR PATERNALISM?

In New Zealand both registers have been set up in response to a break-down or scandal in the provision of medical services. My question is: Why does the development of a register appear to be the chosen government response to such scandals? A feminist analysis of the circumstances leading to the cervical cancer inquiry and the silicone-gel implant debate would suggest that they both involved problems of paternalism in the relationship between the medical profession and their female clients (Lupton, 1994: 84-85; Grace, 1989: 4; White, 1990: 240). In both cases the discourse of the register is one to empower many women in their relations with the medical profession. Through the use of a register, the relationship between a medical practitioner and his or her patient or client is standardised. Ethical problems that might previously have surfaced within this relationship now become the responsibility of the state.

However, the implementation of a register, which operates as a form of consent to medical intervention, also reduces women's choice and by implication their power. The central paradox lies in the utilization of both registers to facilitate informed consent and to organise and regulate particular social practices. In particular, the ICS register shifts the personal act of breast surgery into the non-personal public domain. Both registers are empowering and controlling; they set the choices of individual women and their agency alongside formal structures that reflect lack of choice and control over the consequences of their decisions. Through the registers the outcomes of choice are policed, recorded and appropriated as a form of control either by the state or its agents.

The ambiguity associated with consent is central to cultural politics which link information and understanding about the potential risks involved in a medical procedure to freedom of choice. If women have access to a register that details the potential problems and risks associated with having a breast implant, or not having a smear test, then informed consent is constructed as the solution to issues of trust. Hence, within both registers the problem of trust is reinterpreted as a problem of consent. Through the use of a register, collective problems of trust become individual problems of consent, creating a binary opposition between these terms, because trust as a collective property is contrasted with consent or 'choice' which is seen as an individual property.

## 5.9 FREE CHOICE AS PROBLEMATIC

In Chapter Four<sup>58</sup> I suggested that cultural texts construct cosmetic surgery as a 'lifestyle choice', and that these 'choices' have powerful cultural backing.

Within neo-classical economic theories analyses of 'choice' are often structured by an individual-and-society dichotomy that prioritises individual agency over social forces and societal constraints (Grace, 1989: 53). However, there is a contradiction between an ideology of free choice, based on notions of the empowered consumer, and the way individual choices are limited by particular societal constraints. 'Free choice' is constrained by socio-economic and geographic factors, access to information, individual knowledges, cultural mores, availability of options, technological limitations, government policies and corporate strategies. According to Sandra Coney (1990) the market model operates with an 'illusion of choice' that suggests individuals are able to make

<sup>58</sup> See Section 4.2.

simple decisions between easily understood options based on ready access to accurate and objective information. Choice is a term which implies that:

the options offered to women are entirely beneficial and that the consumer is powerfully placed to select or reject from an attractive range of products...this model in which the market claims to empower the consumers is deceptive and false...although consumers appear to have choices, the market has actually constructed their needs. Women may be able to make individual 'choices', but the range of those choices will be predetermined and outside of their control (Coney, 1990: 20).

In addition choices may have unintended consequences. Helen did not choose to have her breasts 'mutilated', but this is the consequence of her decision to have implants in 1979. Market analysis of choice that link individual decisions to a notion of an empowered consumer are also challenged in the following interview with Anne, a former silicone-gel breast implant client:

I feel I was rail-roaded into having my breasts done. I went along to find out about the possibility of having implants, once I had made that decision it was like stepping onto a roller-coaster, I just went along with the flow - no-one said anything negative to me, it was going to be the answer to all my problems - and I came out with implants in the end (Anne, WIINNZ: June 1993).

Victoria Grace (1989) suggests that because choices are controlled, the focus of sociological inquiry shifts from an analysis of choice as a democratic ideal to a critical analysis of who should control these choices, under what conditions and according to what criteria (Grace, 1989: 51). For example purchasing unsafe consumer products, such as silicone-gel breast implants, can be understood as an activity which does not involve individual choice. Public health agencies respond to unsafe commodities by regulating the supervision and safety of consumer products (Grace, 1989: 49). In New Zealand the Health Department reacted to evidence which suggested that the safety and efficacy of silicone-gel implants could not be determined by regulating the conditions under which breast implants are marketed and sold in New Zealand. After lifting the moratorium on implants the Government decided to use the register to mediate issues of choice, consent and trust within a 'patient as consumer'/'doctor as provider' relationship.

## 5.10 PROBLEMATISING THE REGISTER

Mediation of the doctor/patient relationship through state defined procedures can have its own disadvantages for women. Traditionally feminists have critiqued the state as a patriarchal institution which fundamentally operates in

the interests of men or assumes a paternalistic role in its relationship with women<sup>59</sup>. At the present time, the state has not actively maintained the ICS register, and in this sense has abdicated its responsibility to women who have had or are about to have silicone implants. In this context is ironic perhaps that feminist health activists have sided with the state and the medical profession in advocating ongoing medical surveillance of women with breast implants through the use of the ICS register<sup>60</sup>.

The cervical screening register developed out of a 'politics of prevention'<sup>61</sup>, while the implants containing silicone-gel register arose out of a politics of intervention. Both registers are the outcome of controversy surrounding the relative responsibilities of women, doctors and the state with respect to cervical screening and breast implants. However, the screening register is organised around preventative medicine, the implant register around risk. The cervical screening register is based on ideas about responsible preventative behaviour, and the silicone-gel implant register is based on an assumption that those choosing implants may be engaging in an irresponsible behaviour. The latter register details all the real and potential problems associated with having silicone breast implants. In this sense it actually operates as a warning against having the operation:

Currently the Health Department distributes information about the risks, and before proceeding with the operation, women are required to sign a consent form acknowledging they have read about illness linked to the implants (*The Press*, 11/02/93 & *The Christchurch Mail*, 10/06/93).

Discourses used in the promotion of the registers suggest the women who do not opt-off the Cervical Screening Register are pursuing responsible health care practices<sup>62</sup>, while the women who wish to have silicone breast implants, and are put on to the register as a result of that decision, are constructed as pursuing irresponsible health care practices. The register declaration, which women are

<sup>59</sup> See Franzaway, Court and Connell (1989) especially chapter 2, 'Current Theories'.

<sup>60</sup> The Silicone-gel implants information booklet issued by the Department of Health (1992) lists the following women's groups in its acknowledgments; the National Council of Women of New Zealand, the Federation of Women's Health Councils, the Ministry of Women's Affairs, Fertility Action, and the Women's Division of Federated Farmers.

<sup>61</sup> Austrin, Terry (1993): Seminar on 'Registering Consent' 01/10/93, Sociology Dept. University of Canterbury, NZ.

<sup>62</sup> Cervical Screening is seen as a 'positive health action'. Posters advertising the Canterbury Cervical Screening Programme (CCSP) promote having a cervical smear as 'your responsibility'. The March campaign promoting the screening programme used the theme "Being a Well Woman is a Lifetime Commitment" (CCSP newsletter March 1994).

required to sign before they have their breast implants, contains the following passage:

I recognise that the use of breast implants containing silicone-gel is not endorsed by the New Zealand Government, whether through the Department of Health or otherwise, and that the safety of such implants cannot be confirmed (Department of Health, November 1992).

The Health Department does not endorse the use of silicone-gel breast implants. However, this is of secondary importance to issues of individual freedom, choice and informed consent. The implants containing silicone-gel register employs information to transform an irresponsible act into a responsible act. Responsible choices and irresponsible choices are replaced by having information as a social good as opposed to lacking information (Grace 1989: 114). In this sense the register is not designed to protect women who have silicone-gel breast implants, but to absolve the manufacturers, the state and the plastic surgeons from future liability. In the following conversation Sarah, who had silicone-gel breast implants in 1993, discusses the booklet containing information about the register issued by the Department of Health:

(I think) the booklet is written by a biased party. They say, yes do it, but we don't want the liability. Some aspects of silicone are not scientifically proven, so the more information women have then they are not going to be complaining to the manufacturers and the surgeons, because of things that can go wrong, as it is not unexpected. They are able to make responsible decisions (about having implants). It shows they have really thought about it. From the surgeon's point of view and the patients it is really good (Sarah 21/04/94).

Sarah realises that signing the declaration absolves the government, manufacturers and plastic surgeons from future product liability. She acknowledges problems with the implants, but also suggests the booklet helps women to make informed, and therefore responsible, decisions about their bodies. Clearly Sarah is no 'cultural dupe', but her decision to have implants conforms to the ideal of the empowered consumer acting as a free agent outside of social forces. There is little attention to unintended consequences and societal constraints within market analyses of free choice.

Ironically, both the medical discourses of the plastic surgeons and the gynaecological epidemiologists respectively construct intervention and prevention as legitimate and necessary medical practices. Thus, the women who opt-on to the Implants Containing Silicone-gel Register sit on the cusp of



intersecting medical discourses which simultaneously construct them as requiring medical intervention and as being (ir)responsible for doing so.

Implicitly, both the cervical and Breast implant registers involve issues about medical intervention in women's bodies that also (re)produce ideas about women that relate closely to social constructions of female sexuality. On the one hand, cervical cancer is discussed as a cautionary tale against (heterosexual) promiscuity, while on the other, female heterosexual desirability is linked to the aesthetic appearance of the breast. The former discourse seeks to control women's sexuality, while the latter seeks to enhance it.

Both registers are simultaneously homogenizing and individualising; they create differentiating sets of women. For example they record women as individuals but group them together within the overall category of a register. Both registers produce categories of women; they allow for the production of a continuous medical history. Within the process of reviewing the utility of the register in relation to its capacity to track women over time, the agents who maintain each of the registers assign the women to different groups according to potential risk, at risk/low risk, responsible/irresponsible, pro-active/inactive, 'active'/'signed off'<sup>63</sup>.

The need to preserve confidentiality was the reason given for entrusting plastic surgeons with responsibility for administering the breast implant register. In the following conversation the plastic surgeon (PS) interviewed describes the process of distributing new information about breast implants:

PS: The Health Department will send stuff on if they receive information.

SP: To the women?

PS: No, to plastic surgeons, because the register is meant to be anonymous, so they send it to us, to send on. I am not sure if there is any scheme that checks if we have sent it on (Plastic Surgeon 3: 22/04/94).

While the women are obliged to notify their plastic surgeons of any changes of address, it is entirely the responsibility of the plastic surgeon to maintain the register and to keep clients informed. However, whether women actually receive this information depends on the surgeon and not the state bureaucracy. The Department of Health and the women rely on the voluntary co-operation of

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<sup>63</sup> These terms are used in the Canterbury Cervical Screening Programme to differentiate between women on the register who have normal smears ('active') and women who are "signed off" meaning they are 'having investigations or treatment for cervical abnormalities' (CCSP Newsletter, March 1993).

the administering agents; this trust is based on assumptions about the integrity of the medical profession. While a decentralised or un-coordinated register is thought to ensure greater confidentiality, a major disadvantage of this scheme is that it is easier for groups of women to 'fall out' of the system. In the following conversation the plastic surgeon interviewed describes his recent experience of this problem:

SP: What happens to the women when a plastic surgeon retires?

PS: That is a very sore point at the moment because one of our number has died,... and for some reason it was thought to be difficult to keep his notes (and) they have all been shredded. So we do not know where his patients stand and I've had a number of his patients who come back and they have not known what prostheses they have got in. And the hospitals they've had the operations at destroyed the notes after seven years. So there is nothing left. I've already made my arrangements. If something happens to me they will come here to my colleague and he will look after them... (Plastic Surgeon 3: 22/04/94).

The plastic surgeons use the register as a record of informed consent. When a plastic surgeon dies informed consent is no longer relevant; issues of confidentiality are most prominent, which could explain why the patient notes were destroyed in the above example. Incidences of 'falling out' are increased because the general practitioners do not have to be informed when their patients have a cosmetic surgery procedure. In the following conversation the plastic surgeon interviewed suggests most of his clients prefer that their cosmetic surgery remains a private matter:

...mostly they (potential clients) come on their own accord these days, and that is partly because cosmetic surgery is still not well accepted in society. In New Zealand it is something you don't mention, you don't talk about it, and therefore GP's are a bit against it too; tampering with Gods work, so to speak. So a lot of people feel they don't want their GP's to know or their GP's secretaries... (Plastic Surgeon 3: 22/04/94).

Often the plastic surgeon has the only record of an individual's aesthetic surgery history. It appears that unlike most other forms of specialist intervention cosmetic surgery procedures are not attached to an individual's lifetime medical records despite the existence of the ICS register. While the ICS register uses 'informed consent' to absolve the manufacturers and the surgeons from future product liability, the following section considers how unscientific personal knowledges can be used to challenge the dominant discourses and practices of medicine.

## 5.11 COUNTER DISCOURSE AND SUBJUGATED KNOWLEDGES

In the 1960s and 1970s the development of silicone-gel implant technologies facilitated the creation of (small) breasts as additional objects for analysis and a new category of subjects for medical intervention and control. This process is indicated in the following cosmetic surgery discourse which constructs the 'natural' or 'normal' breast and identifies small breasts as a form of pathology:

Implants are necessary to augment a 'female' breast that has not developed sufficiently to give the patient a normal concept of breast image...These is a substantial and enlarging body of medical opinion to the effect that these DEFORMITIES [small breasts] are really a disease which in most patients results in feelings of inadequacy<sup>64</sup>

The medical discourses of cosmetic surgery, indicated above and in Chapter Four, can be described as authoritative knowledges legitimated through the dominant discourses and practices of medicine. The following section provides an explanation of 'counter discourse' and considers its use within feminist critiques of the medicalisation of women's bodies. This is followed by an analysis of the way women with implants developed new knowledges and support networks in order to counteract the use of silicone-gel breast implants and to challenge the authoritative position of the plastic surgeons.

In Chapter Two<sup>65</sup> I discussed discourse as a meaning-constituting system, tied to subjective notions, understandings and practices of culture and located within historically-specific contexts of social relations and power. (Foucault has suggested it is possible for different and even contradictory discourses to exist within the same social field (Foucault, 1978: 102).) Importantly, discourses cannot be seen in terms of a binary opposition between legitimate or illegitimate knowledges and practices, nor in terms of a hierarchy between dominant and subordinate discursive positions. Discourses comprise a multiplicity of intersecting discursive elements, including silences and resistances, that occupy various positions within a network of unstable power relations. For Foucault, 'discourse can be both an instrument and an effect of power, but also...a point of resistance and a starting point for an opposing strategy' (Foucault, 1978: 101). It is in this space between what is said and what is concealed, that it is possible to challenge the existing discursive order. Foucault termed these resistant or concealed discourses, 'reverse discourses'.

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<sup>64</sup> Memo to the FDA from the American Society of Plastic and Reconstructive Surgeons. Sources: *Donohue* 30/06/93, *Mother Jones*, January/February 1992 and Susan Faludi, (1992) p 250. Capitals my emphasis.

<sup>65</sup> See Section 2. 2.

According to Foucault, reverse discourses speak on their own behalf, they demand that their legitimacy be acknowledged, often in the same vocabulary, using the same categories by which they were originally disqualified (Foucault, 1978: 101). [Foucault called the specific personal and subjective form of reverse discourse 'subjugated knowledges'.]

Foucault defined subjugated knowledge as 'a particular, local, regional knowledge, a differential knowledge incapable of unanimity' (Foucault, 1980: 82). Subjugated knowledges are forms of knowledge and experience that have been disqualified from the hierarchy of knowledges and sciences as inadequate or unscientific. These 'naive knowledges' or 'popular knowledges' are more specific than general commonsense knowledges; they are a set of understandings that run parallel and marginal to the dominant discourses and knowledges within a particular social field (for example, Foucault suggested the knowledges and experiences of the patient are subordinated to, or disqualified within, the knowledge of medicine). According to Foucault, it is in the potential for subjugated knowledges to challenge existing hierarchies of knowledge that critical discourse has discovered their 'essential force' (Foucault, 1980: 82). Hence, Foucault argued that by virtue of their opposition the re-emergence of these subjugated knowledges has the potential to form the basis of a powerful critique of the dominant discourses to which they are addressed.

[In the second half of this century feminist challenges to the medicalisation of women's bodies have not only questioned medical practices, but also contested the way meaning is constituted within the language of medicine.] Central to this analysis has been a recognition that language is not an impartial or objective reflection of the world, but rather a meaning constituting system whereby significations are inscribed through discourse. Paula Treichler (1990) employs the term "counter-discourse" to argue that discourse itself is the site where social practices are made intelligible:

Counter-discourse does not rise as a pure autonomous radical language embodying the purity of a new politics. Rather it arises from within the dominant discourse and learns to inhabit it from the inside out... definitions are social, cultural, and political as well as linguistic...they are constructed by specific speakers with specific aims and interests (Treichler, 1990: 132).

As cosmetic surgery issues are increasingly taken up as cultural rather than simply medical issues, more space is opened up for politicising them (Sawicki, 1991: 88). Throughout the silicone-gel breast implant debate the complex

moral and ethical issues involved in targeting the bodies of otherwise healthy, 'normal' women for aesthetic correction and improvement, through the use of invasive cosmetic and plastic surgery technologies, has been of secondary importance to the unsatisfactory outcomes produced from this form of medical intervention.

New cosmetic and plastic surgery technologies threaten to reproduce and enhance existing patriarchal power relations by creating new subjects and objects for medical classification and correction. They also create the possibility for new sites of disruption and resistance (Sawicki, 1991: pp. 84-88). The silicone breast implant debate provides a good example of the way the subjugated knowledges have challenged the dominant discourse of medicine. Women who have undergone silicone-gel breast implants are sharing their experiences, demanding improvements and exposing current inadequacies in this cosmetic surgery procedure. The following section considers how some women at the centre of the debate have negotiated this medical, legal and cultural milieu.

## **5.12 COUNTER-DISCOURSES AND PRACTICES WITHIN THE WOMEN'S IMPLANT NETWORK**

In general the public discourses on silicone-gel breast implants, available through the New Zealand print media, subordinated the personal experiences of women with implants to legal processes, government responses and medical interpretations of the controversy. During this time individual women were quietly working behind the scenes developing support networks for women who had silicone-gel breast implants. Although these networks were highly organised, their members preferred to remain anonymous, and their activities were not widely publicised beyond the women's health information service. The Foucauldian notion of subjugated knowledges and counter-discourse can be used to explore the activities of the women involved in the Christchurch branch of the Women's Implant Information Network, New Zealand (WIINNZ) support group. The network operated independently of the medical profession; their differential knowledges run parallel and marginal to dominant medical interpretations of the silicone-gel implant controversy. This network was able to utilize the knowledges and experiences of women in order to subvert the authoritative power of the medical profession.

In Christchurch the breast implant support group was developed and organised by women who had experienced or were experiencing problems with their implants. The Christchurch women developed networks with similar implant support groups throughout New Zealand and Australia and they liaise with women's health collectives traditionally considered 'feminist' and/or 'activist'. In New Zealand implant support groups can be contacted through THAW, The Women's Health Information Service and Fertility Action. The breast implant controversy has forged an alliance between on the one hand, women who do not identify personally as 'feminist', and on the other, groups of women who work within organisations that are readily identifiable as incorporating feminist practices and/or politicising feminist concerns. (Although the Christchurch branch of the Women's Implant Information Network, New Zealand (WIINNZ) is not a feminist organisation, the work they do can be interpreted as incorporating some traditionally 'feminist' practices.)

The women collect, distribute and swap a range of information concerning breast implants, including; newspaper and magazine articles, legal documents, medical articles and anecdotal evidence. They provide legal and medical contacts and are involved in advising and counselling women who have breast implants. The group has a list of sympathetic GPs and provide advice on how to approach a plastic surgeon. They publicise the danger of silicone-gel implants and they talk about their experiences and their symptoms. In the following conversation one of the founding members of the Christchurch support group discusses the importance of providing information and sharing experiences:

We thought it was important to publicise the existence of the breast implant support group here in Christchurch, so that women who had breast implants would know where they could seek information and contact with other women who had been through, or were going through, similar experiences to ourselves (Mary, WIINNZ: June 1993).

While all of the women in the group acknowledged the importance of publicising their experiences, many of them did not like the process of doing this. They did not like the way women who had similar experiences to themselves were portrayed in the media, either as victims, as vain, naive or stupid. In contrast to these media constructions of women who have cosmetic surgery, Mary is able to provide an alternative sympathetic interpretation of the debate and the factors that might have influenced a woman's decision to have breast implants:

We are exactly the wrong group of women to be experiencing problems like these. We had our breasts enlarged in the first place because of low self esteem and a poor concept of our own body image. Body image was or is important to us, and now when we are faced with having our implants removed, and the possibility of our breasts or bodies being deformed because of that, well psychologically it is really hard for us to make that adjustment. A lot of us have had implants because our partners wanted them, we did it thinking it would save our marriages. Of course it didn't, and deep down maybe some of us feel we have been rejected because our bodies didn't measure up. So you can imagine, that some women might be hesitant at having their implants removed, because of the fear of rejection by their new partners, and the possibility that they themselves might feel unloved or unlovable (Mary, WIINNZ: June 1993).

Mary provides a perceptive analysis of the external factors that often persuade individual women to have a breast augmentation. She is able to use her personal experience of breast augmentation to simultaneously critique and understand why women have this cosmetic surgery procedure.

Within the network the women provide support and information to women, they use their personal knowledges to challenge medical authority and they seek legal and political solutions to their grievances. The support work these women do can be interpreted as embodying traditional feminist practices and goals. However, there is a contradiction between this work and the focus of their political activism. Cosmetic surgery has been targeted by some feminist writers on embodiment as a form of compliance to oppressive male expectations about ideal female body size. The women in the implant network are powerfully placed to bring their personal experiences to a critique breast augmentation. However, they do not extend these specific criticisms to other forms of cosmetic surgery or to an analysis of female beauty practices as a whole.

Mary considers it is important to identify with, or be sympathetic to, women who have had cosmetic surgery or might be considering having cosmetic surgery. In the following conversation, Mary draws on her personal experiences to explain why she feels it is important to provide this support:

As well as my implants, I've had plastic surgery on my nose and my chin, so I'm not against it. I used to be really shy and self conscious about my face and my breasts, plastic surgery gave me a life and a personality, so I don't think implants should be banned, just restricted (Mary, WIINNZ: June 1993).

Although Mary had her breast implants removed in 1993, she felt women should still be able to make their own decisions about breast augmentation; as

long as they had access to information about the real and potential dangers involved.

The women use their personal knowledges and experiences to contest a particular cosmetic surgery procedure they consider to be unsafe. These debates are played out in public, either through the courts or through the media. The evidence provided by individual women about problems they have experienced with breast implants is considered anecdotal<sup>66</sup> because their stories are not supported within the medical community. According to Sandra Coney, personal knowledge, experience and reality have become marginalised within medical discourse:

'She cannot know since by virtue of being both 'patient' and woman, she is simultaneously subjective and subordinate' (Coney, 1991: 52).

However by pooling their shared experiences the women achieve a form of legitimacy that allows them to challenge authoritative medical interpretations of their symptoms and experiences. In the following conversation Karen describes the problems she encountered obtaining the co-operation of a plastic surgeon after she decided to have her implants removed:

A year after I received my implants, I went back to the plastic surgeon and told him, because of all the adverse publicity, I had decided to have them removed. He was not happy about my decision. During the examination he told me they felt normal. But I still wanted them out. So then he said to me: "How do you think I'm going to feel destroying my own handiwork?" During the removal he found both the implants had ruptured and I think he was quite shocked about that. I hate to think what would have happened if he managed to persuade me to leave them in (Karen, WIINN: June 1993).

The plastic surgeon did not consider Karen's rationale for having her implants removed to be 'medically legitimate'. As a result of these experiences the women in the support group now encourage women wanting to have their implants removed to provide recognised concerns, such as mammography screening, to their plastic surgeons. In the following conversation Mary explains why she advises women to tell the plastic surgeons as little as possible:

<sup>66</sup> Silbey, Paula J. 'Physicians Increasingly Link Silicone to New Diseases' in *Medical and Legal Aspects of Breast Implants* Vol. 1, No. 3/Feb. 1993. In addition, when women give evidence in court, about the problems they have experienced with breast implants, this information is considered anecdotal.



The plastic surgeons are not interested in the symptoms the women (who are having problems with their implants) are experiencing. I advise women who want their implants out, just to go along to the plastic surgeon and say, I've decided to have my implants removed, and not to mention the problems. Because the plastic surgeons are not interested, their eyes glaze over and they turn off. They don't want to listen to the women, and they don't have the time to do the counselling work that many of the women need (Mary, WIINNZ: June 1993).

Mary advises women to use 'silence' as a form of resistance to clinical disdain, for the symptoms and concerns of women with implants, within the medical profession. She suggests that women considering implant removal should tell the surgeons what they want to hear so they can get their implants removed without being made to feel their concerns are unfounded, and therefore, irrational.

The stories of implant failure provided by both Karen and Helen describe more serious problems with the implants than many plastic surgeons want to acknowledge. One of the plastic surgeons I talked to suggested the chances of women with silicone-gel breast implants developing auto-immune disorders or rheumatoid arthritis was probably the same as women in the general population:

...in New Zealand I don't know how many people have had prostheses but my guess is that there may be up to twenty thousand people in New Zealand with prostheses, if one percent develop...that would be two hundred people with rheumatoid arthritis presenting with problems that happen to have had prostheses and in fact one hundred people have actually come forward to Okkerse (the Wellington lawyer)... (Plastic Surgeon 1: 14/07/93)

In contrast to abstract statistical assessments of risk, which tend to depersonalise the dangers involved in a medical operation, stories about implant failure based on individual experience have the advantage of being able to personalise the unintended consequences that could result from an individual's decision to have a breast augmentation. The silicone-gel breast implant controversy has reduced the number of women opting to have this form of cosmetic surgery, and many women are now more aware of the potential dangers involved in not only breast implant surgery but in cosmetic surgery in general.

### 5.13 SUMMARY

This chapter has explored several perspectives on the silicone-gel breast implant controversy. It was suggested that throughout the controversy the New Zealand print media acted as important gatekeepers of information about the American origins of the debate. In New Zealand the way the media represented the opinions of professional groups structured and influenced popular understandings of the controversy. Print media discourses connected breast implants to traditional notions of mothering and femininity. The development of Implants Containing Silicone register was documented, and notions of 'informed consent' and 'choice' were problematised. The Foucauldian notion of subjugated knowledges and counter-discourse was employed to explore how women who experienced problems with their breast implants attempted to make sense of the controversy. The next chapter provides some general conclusions to the thesis.

## CHAPTER SIX

### WHAT GETS DONE THROUGH COSMETIC SURGERY?

The focus of this thesis has been the relationships between breast surgery femininity, sexuality and identity. I have argued that taking the agency of women seriously means acknowledging the contradictory and ambiguous practices of women who engage in cosmetic surgery. Although my interviews with clients have not been extensive, they do indicate that women respond to cosmetic surgery in ways that are simultaneously ambivalent, contradictory and pleasurable.

I have argued that both the 'oppression' model and the 'discourse' model are relevant to an analysis of cosmetic surgery. This analysis of cosmetic surgery as a set of discursive practices has been aimed at redressing an imbalance within the literature towards feminist analyses of cosmetic surgery as oppression. Most feminists who write about feminine embodiment see cosmetic surgery as a manifestation of oppression. Approaches to cosmetic surgery which imply that women clients are 'cultural dupes' cannot do justice to the agency and the pleasures which women often express as a result of their cosmetic surgery experiences. The talk of women who engage in elective breast surgery often incorporates resistant or critical discourses about cosmetic surgery which challenge implicit understandings of them as cultural dupes.

I have used conversations with women who use cosmetic surgery to problematise understandings that homogenise the experiences of women clients. Analyses of cosmetic surgery based on advertisements, magazines, newspapers and television programmes exclude some of the important dimensions of cultural production that lie outside these texts. My conversations with women who have cosmetic surgery were directed at challenging the exclusive focus on words and images in the print media in much feminist writing about plastic and cosmetic surgery. Conversations with former cosmetic surgery clients suggest that women not only reflect critically on their decisions to alter the size of their breasts, but also that they challenge dominant assumptions about the women who have this form of cosmetic surgery.

All of the women interviewed justified their decisions to have elective breast surgery in terms of the opportunities they felt their surgery provided. For example, breast augmentation can be set in the context of the economic opportunities that might result from this cosmetic surgery procedure. Isabel thought her cosmetic surgery was 'a good investment', she used money from her divorce settlement to rework her body into a shape that she thought would be attractive to a potential partner. Sarah's breast augmentation meant she was able to be more effective in her occupation as a breast implant sales representative. The way in which Sarah talked about 'doing' 'sexuality' and 'professionalism', provided a strong statement of resistance to understandings often attached to women who have breast augmentation. She simultaneously engaged with discourses that link sexuality to breast size and sought to resist them through crafting a more professional image for herself through hairstyle and clothing. Breast augmentation is obviously a source of pleasure: Sarah thought her implants were 'wonderful', while Isabel said she was 'really pleased' with the results of her surgery.

Most of the women interviewed engaged problematically with their decisions to have elective breast surgery. For example, Isabel suggested she was a 'victim' of cultural expectations about women but also defended her decision to have cosmetic surgery by saying it was 'her business'. While Isabel suggested that women might not feel compelled to have breast augmentations if they did not encounter men's expectations about the ideal female body, she also said that the gaze of other women was an important factor that influenced her decision to have a breast augmentation. Lucy commented on the sexualisation of breast in our culture and suggested that her breast reduction turned out to be an effective strategy of resistance to the unspoken fascination men had with her breasts.

The discourses emanating from breast surgery experiences are not unique to this form of cosmetic surgery. Feminist debates surrounding cosmetic surgery and beauty work, in fact, often parallel debates associated with clitoridectomy. Cosmetic genital surgery is available in Western industrialised societies and, like clitoridectomy, is used in ways that are deeply contradictory and ambiguous. Cultural practices that involve cutting into the female body illustrate the way in which the female body is used and disciplined within different contexts in order to secure particular forms of 'femininity'. Rather than condemning these cultural practices as 'unnatural' or 'aesthetic normalisation' I have argued that feminist analysis needs to explore the

relationship between these ideals of femininity and the surgical alteration of the female body.

Language is not a neutral or objective reflection of the world; it provides a crucial point of entry for understanding how social relations are conceived, organised, institutionalised and experienced. I have argued that it is important to recognise that feminist alternatives to cosmetic surgery are social constructions. Feminist critiques of cosmetic surgery often fail to recognise that these alternatives may also be normalising discourses about what constitutes the 'natural' body. This suggests that we may need to reflect critically on these alternative feminist discourses and practices, in order to problematise feminist ideas about 'the natural' and our constructions of appropriate ways to rework and present the body within different cultural contexts.

The understandings which people bring to images, discourses and practices of cosmetic surgery are constantly contested and (re)negotiated. Cosmetic surgery can be seen as a discursive field and a set of social processes that produce particular meanings of femininity and provide subject positions for individuals. Cosmetic surgery has a dual meaning as both a medical and a lifestyle event. It represents a symbolic engagement with the social and provides one example of the way identities are (re)crafted through consumer culture.

Men, as well as women, engage with cosmetic surgery practices. The marketing, selling and buying of cosmetic surgery technologies is a product of medical definitions of femininity and masculinity. These gendered definitions of the body are culturally specific. I have argued that the emergence of an aesthetic masculine ideal, and men's increasing engagement in cosmetic surgery, disrupts the binary oppositions constituting relations of looking and calls into question gendered assumptions about the way women and men rework their bodies.

My analysis has drawn heavily on Foucauldian theory and feminist appropriations of Foucault. According to Foucault the body is produced through power; it is a site of normalisation, intervention and control. I have applied Foucauldian theories of 'bio-power' and 'subjugated knowledges' to an analysis of cosmetic surgery as a site of both normalisation and individual agency. Using Foucault's ideas it was possible to reflect on the way in which discourses and practices such as those deployed by the surgical corsetiere and

the cosmetic surgeon reproduce, reconstruct and mobilise certain ideals of femininity which describe and inscribe the female body.

Foucault's exploration of the way in which bodies are used and disciplined through technologies of surveillance and examination was also particularly relevant to this analysis of cosmetic surgery. Conversations with plastic surgeons and analysis of extracts from the print media suggest that plastic surgeons construct themselves as the 'experts' who decide which body shapes and features fall into the category of an aesthetic 'defect'. The measurement of the 'ideal' breast or body shape is based on visual appraisals of women who are potential clients. I discussed a particular piece of research directed at using a set of procedures to determine the correct site for the placement of the nipple, which involved taking measurements from a sample of nurses who were thought to be the 'ideal' shape. The idiosyncratic judgements of the plastic surgeons in this research team determined which the available nurses were 'ideal', and therefore, qualified for measurement. In this context cosmetic surgery can be seen as a discipline of the body and as form of 'knowledge-power', based on the explicit calculation of idealised body shapes developed through medical techniques of surveillance and examination.

Generalisations about plastic and cosmetic surgery often obscure rather than clarify the way in which these ideas and procedures are applied to the body. The discursive practices surrounding cosmetic surgery and surgical corsetry play on the use of artifice to construct more 'natural' body shapes for women. Conversations with both surgical corsetieres and plastic surgeons suggest that definitions of 'normal' breast shape are based on the subjective judgements of the surgeons, corsetieres and their clients. Sizing for breast augmentation is a negotiated process between the client and the plastic surgeon. For example, one plastic surgeon organised breast augmentation around the bra size chosen by the clients while another worked from 'girlie' magazine photographs supplied by clients.

I have argued that the plastic and cosmetic surgery 'industry' is not a monolithic entity, but a contested field characterised by disputes over professional boundaries, access to patients and potential patients, safety and effectiveness issues and concerns about professional autonomy. In addition, conversations with plastic surgeons suggest that the binary opposition constituting 'legitimate' plastic and reconstructive surgery and 'illegitimate' cosmetic and aesthetic

surgery is discursively constructed and not due to any intrinsic differences in surgical techniques or desired outcomes.

I applied the Foucauldian notion of 'bio-power' to an analysis of the Implants Containing Silicone-gel (ICS) register. The silicone-gel implant controversy illustrates how the body is positioned within a network of institutional structures that regulate individual behaviour through technologies of surveillance and examination. A register can be interpreted as a modern technology of power through which a constructed medical gaze is able to organise and regulate particular social practices. The ICS register is used to facilitate informed consent and to manage and control women with breast implants. The ICS register employs information to transform a responsible act into an irresponsible act, in this sense it constructs a binary opposition between collective issues of trust and individual issues of consent.

The most exciting aspect of Foucault's method of analysis is its potential to disrupt normative discourses and practices relating to 'power/knowledge' and 'scientific authority'. I have attempted to capture the disruptive potential of Foucauldian analysis by crafting multiple narratives of cosmetic surgery as contradiction, ambiguity, pleasure and risk. More analysis is needed that addresses ambiguity and contradiction, and acknowledge the concrete social practices that produce difference, while continuing to act politically in relation to the material and institutional effects of practices which construct gendered bodies.

As this research has focused on 'doing breast work' there were many aspects of cosmetic surgery that were not covered in depth or were beyond the scope of the thesis. Two examples are tattooing and 'cosmetic' dental surgery. Another example is gender reassignment, which simultaneously obscures the binary oppositions constituting male/female and masculine/feminine and reinforces the idea that challenges to conventional ideas about gender have to be associated with changing the genitals.

In addition, very little is known about men's engagement in cosmetic surgery. It is difficult to talk about how cosmetic surgery technologies target women's bodies without considering how cosmetic surgery is used by men. A lack of research in this field means it is currently not possible to use men's experience of cosmetic surgery to challenge theoretical assumptions about how men experience and rework their bodies. Further empirical research is also needed

to provide a more comprehensive comparative analysis of the similarities and differences involved in the way in which men and women recraft identity through cosmetic surgery.

There is a need for feminists to continue to develop theoretical analyses that do not provide reified prescriptive positions on medical technologies, while at the same time maintaining a critical engagement with medicalising discourses of the body. An extension of my analysis of cosmetic surgery to other areas involving the medicalisation of the body, - for example, to hormone replacement therapy, new reproductive technologies, pregnancy and childbirth - has the potential to provide more open and speculative reflections on how social relations are perceived, institutionalised and experienced. These issues are raised in this conclusion as potential agendas for further research.

The purpose of this thesis has been to problematise feminist theories about how feminine identities are crafted through cosmetic surgery. I have argued that cosmetic surgery fractures the boundary between 'science' and 'nature', disrupting cultural assumptions that modern ideals of femininity are somehow 'natural' and 'universal'. While cosmetic surgery disrupts the notion of a 'natural' femininity, it also involves sets of discourses and practices which construct and reinforce a narrow definition of femininity as the 'ideal'. 'Breast work' thus simultaneously reinforces and disrupts cultural ideals of femininity. This is what gets done through cosmetic surgery.



## APPENDIX ONE

### REFLECTIONS ON METHODOLOGY<sup>1</sup>

#### WHY BREASTS?

This study explores the way female identities are crafted through cosmetic surgery. When I first proposed doing a Master's Thesis on cosmetic surgery it was my intention to consider all forms of cosmetic surgery. However, it soon became obvious that such an endeavour was too ambitious and that a narrower focus was needed. In consultation with my supervisors it was decided that the thesis should focus either on forms of breast surgery or on liposuction. Both of these cosmetic surgery procedures were particularly interesting at the time. Breast augmentation was topical because of the on-going controversy surrounding silicone-gel breast implants. Liposuction was also interesting as an example of a completely new concept in cosmetic surgery. Both procedures were generating internal debates among practitioners which focused on issues of safety and professional boundaries.

Finally I decided to investigate the issues surrounding cosmetic surgery through different forms of elective breast surgery for women. This limited the research in some ways - it meant I did not interview any men and that I was unable to pursue some potentially interesting issues associated with other cosmetic surgery procedures. However, the focus on 'breast work' connected to a feminist literature on 'breasted experience'. It seems obvious to me now that I should have chosen to study cosmetic surgery through elective breast surgery, but it was not such an obvious choice when I started the thesis.

I had already decided before I began the research that I wanted to apply aspects of Foucauldian notions of 'bio-power', 'discourse' and 'resistance' to my analysis of cosmetic surgery. I was particularly interested in looking at 'resistance' and exploring the agency of women involved in cosmetic surgery. However, I did not know what this might entail. The final document is vastly different from the sort of thesis I envisioned when I completed my research

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<sup>1</sup> During the last two years I have kept a file of all the technical work that goes into putting a thesis together, recording letters I'd written and received, accounts about how contacts were made, potential ideas, personal narratives and thesis problems and frustrations. This methodological appendix incorporates excerpts from this file.

proposal in July 1992. In that proposal I included the following 'critical questions':

*Is cosmetic surgery a part of an ongoing trend towards increasing medicalisation of the healthy female body?*

*Who uses cosmetic surgery? Age? Income? Occupation?  
Who is affected by the promotion of cosmetic surgery?*

*What are the processes through which new cosmetic surgery technologies become widely accepted (throughout the Western World) and used by women? How are technologies associated with changing body shape promoted? How do women respond to these promotions?*

*How is the political economy of cosmetic surgery organised in (Christchurch) New Zealand?*

*What is the relationship between cosmetic surgery and idealised images of women's bodies? To what extent is the acceptance and use of cosmetic surgery, as an option for women who wish to maintain or achieve a particular ideal of femininity, a social phenomenon?*

*What are the constraining and enabling consequences of cosmetic surgery? How does it fit in with postmodern theories relating to strategies of resistance and empowerment?*

*How adequately does existing sociological/feminist/postmodern theory explain the place of cosmetic surgery within contemporary Western society?*

I wanted to generate a variety of narratives about cosmetic surgery and to give women space to tell their stories, without making judgements about the 'political correctness' of their cosmetic surgery decisions. My subjective position on cosmetic surgery has also changed, from one of a distant sympathetic researcher - someone who would not choose cosmetic surgery for myself but who is interested in why others did - to the position of a person for whom this territory is no longer so unfamiliar. In November 1992 I wrote the following reflexive commentary for a seminar presentation on my thesis:

I was originally drawn to an investigation of cosmetic surgery because, as someone who has had surgical intervention in the recent past, I could not imagine how anyone could elect to go through the pain and trauma of 'unnecessary' (cosmetic) surgery. The intricate relations of this apparent collusion between the women, the cosmetic surgeons, medicine, advertising, the beauty literature and the media intrigued me. I wanted to find out what made some women choose cosmetic surgery, when it was not an option I would consider for myself. At just over five foot tall and less than 45kgs in weight, I feel I have no need to employ the expertise of a cosmetic surgeon, and I certainly do not aspire to the sculptured feminine bodies represented within advertising and the media. However, I do derive personal pleasure from doing femininity work,

and my choice to actively construct my body through make-up and clothes, to achieve an aesthetic ideal that gives me pleasure, is in many ways similar to the way other women and men actively use cosmetic surgery to construct their bodies according to a particular aesthetic ideal that gives them pleasure (November 1992).

Today I would not position myself in the same way. I now see myself as an 'insider' rather than an 'outsider'. I accept that under particular circumstances I too would choose cosmetic surgery. This realisation has come to me only recently and puts me in the rather ambivalent position of having to address the question of how can I be a feminist and vain?<sup>2</sup>

My experience of reading cosmetic surgery texts is one of ambivalence<sup>3</sup>. I currently do not desire to transform my body through cosmetic surgery technologies. I find it difficult to watch video footage of any cosmetic surgery operation and I cannot watch liposuction operations. The pleasure I get from many texts about cosmetic surgery is the way they communicate ideas about how embodiment is constructed through social practices. Cosmetic breast surgery is one of those social practices.

## FINDING PEOPLE - ACCIDENTAL NETWORKS, FORMAL CONTACTS

I interviewed fourteen people in total for this research project, eleven women and three male plastic surgeons<sup>4</sup>. Two of the women were surgical corsetieres and the remaining nine women had had some form of cosmetic surgery on their breasts. Most of the interviews were tape-recorded and transcribed. Interviews were conducted in two ways: informally (with the people I knew), and formally with people contacted specifically for the research. I had on-

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<sup>2</sup> 07/07/94 - I found out earlier today that I have to have another operation, one that will leave a scar across my throat. My immediate reaction was that I didn't want the operation, because I didn't want a scar in such an obvious place. The specialist replied that the surgeon could disguise the scar by incorporating it into the natural folds of skin on my neck. To try and impress on the specialist how important this was to me, I found my self saying that if the scar was obvious I would be going to a plastic surgeon to have it revisioned! - Suzanne

<sup>3</sup> This ambivalence was heighten as I recently viewed former cosmetic surgery clients vying for the title of 'Miss Most Improved' on the *'Phil Donohue Show'*. Donohue used the format of a beauty pageant to determine which cosmetic surgery technique produced the best aesthetic result. Among the contestants were; 'Miss Breast Implant', 'Miss Face Life', 'Miss Eye and Neck Tuck', Miss Liposuction-Thighs, 'Miss Spider Vein', 'Miss Bonded Teeth', 'Miss Tummy Tuck' and the eventual winner 'Miss Laser Peel'. The contestants were judged by the studio audience. (TV3 14/03/94 and repeated on the 16/09/94).

<sup>4</sup> As there is only one registered female plastic surgeon in New Zealand I felt she would be too easy to identify - and therefore chose not to seek an interview with her.

going conversations with Helen, attended one support group meeting with women involved in the Women's Implant Information Network New Zealand, was present at a meeting of the mastectomy support group at which a visiting surgical corsetiere spoke about and displayed the latest range of prostheses available to women with mastectomies. Some of the women clients were relatives and close friends.

Terry Austrin and Helen have read and commented on Chapter Five. Pamela has also read and commented on Chapter Three. None of the plastic surgeons wanted transcripts of their interviews, but requested a copy of the final document. Sarah and Isabel also requested copies of the chapters in which they appear.

When I began my thesis I thought that I did not know anyone who had received cosmetic surgery, and I knew only one person who had had a breast reduction. (I make this distinction between cosmetic surgery and breast reduction deliberately as it was a distinction I saw as less problematic when I began the thesis). Over the course of researching and writing this thesis I discovered among my extended family and friends a liposuction client, two nose remodeling clients, two breast reduction clients, a breast implant client, a mastectomy/reconstruction client, two scar revision clients, one spider vein correction client, a plastic surgery registrar, and a plastic surgeon's nurse. I call these contacts 'accidental networks'; I did not formally seek them out, they either just happened, circumstances for example:

Mother: (Pamela's) decided to have a breast reconstruction, and she will be staying with us for a couple of days (March, 1992).

or were brought to my attention in a very informal way:

Aunty J: Did you know D's working for a plastic surgeon now? Maybe you should contact her. She would be very interested in what you are doing (December 1993).

In addition to these informal networks I also made contact with Dawn, Sarah, Isabel, the plastic surgeons and the surgical corsetieres through formal channels.

Once I had decided to focus on elective breast surgery as a means of investigating cosmetic surgery, my first contact was with the Cancer Society

(as it seemed that women who had lost a breast would have a unique perspective on how breasts are connected to ideas about identity and femininity). Through talking to the women in the mastectomy support group and the Cancer Society I found out about surgical corsetieres. I made contact with both of the corsetieres interviewed for the thesis through the mastectomy support group. This is how I was introduced to one of the surgical corsetieres<sup>5</sup>:

I greet Dawn, she asks me how the interview transcribed. 'Really good, I'm interested in interviewing a surgical corsetiere'. Dawn replies: 'Oh, (name of the surgical corsetiere) is here, I'll introduce you to her, she is the best surgical corsetiere in Christchurch'. I look around the room, wondering which woman is the surgical corsetiere. It turns out to be the woman I showed how to work the coffee machine minutes before. Dawn introduces us: 'This is Suzanne she is doing a master's thesis on cosmetic and plastic surgery and would like to talk to you'. The surgical corsetiere is surprised at my interest in cosmetic surgery. She can't quite understand why I want to look a cosmetic and plastic surgery, and more specifically why I want to interview her. She thinks it would be more productive for me to interview the women who have had mastectomies.

We talk briefly before the meeting. She begins to tell me what she thinks about cosmetic surgery, it is one of those instances when you wish you had a tape recorder. The surgical corsetiere thinks I should do research on hands: 'They are doing really amazing cosmetic surgery on the hands at Burwood... Did you know with breast reduction the cosmetic surgeon decides what shape the breasts are going to be. I don't know how a cosmetic surgeon can judge what size and shape to mold the breasts when the woman is lying on her back.' After the support group meeting we arrange an appointment for an interview (3/11/92).

The interviews with the plastic surgeons followed a set list of questions that I had prepared and sent to them prior to the interviews<sup>6</sup>. I had arranged with the first plastic surgeon I interviewed to have a one hour appointment at the end of clinic (from five until six) so that it would not matter if we ran over time. The interview finished at 8pm. This three hour interview was an amazing research opportunity, one of those rare occasions where the information recorded is rich and full of insights into the issues you are investigating. This one interview could have been the basis for a thesis in its own right.

I interviewed one of the Auckland plastic surgeons during his lunch hour and the other during clinic hours. In comparison to the interview with the first plastic surgeon, both of these interviews were heavily constrained by time and

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<sup>5</sup> What follows is an extract from my fieldnotes. These note are used extensively in this appendix to convey my thoughts at the time the research was being done.

<sup>6</sup> The questions I used in the interviews with the plastic surgeons, Dawn and the Christchurch based surgical corsetiere are attached to the end of this appendix.

lasted approximately 40 minutes. Much of this interview material confirmed the information already provided by the interview with the first plastic surgeon.

An important informal contact was Helen. Helen and I talked extensively about her experiences of breast implant failure. I had originally intended to weave Helen's story through Chapter Five, but I considered that a great deal of the information provided by Helen was intensely personal, and as everyone in my family knew Helen was going to be interviewed as part of my thesis research, for reasons of confidentiality I eventually decided to use only a minimal amount of this information. The following extract from my fieldnotes provides a brief background to Helen's story:

Helen is a close relative. I arrived at her house on this particular day because I knew she was expecting the results from her tissue biopsy. Helen had been unwell for several months, had already been tested for Hodgkinson's Disease and Leukaemia, recently she had found a lump under her arm and again the doctors were testing for cancer. Helen was on the telephone when I arrived, I could tell by the look on her face that it was the oncology specialist. She finished the telephone conversation looked at me and said: 'It's not cancer, it's silicone. I've had implants...' Helen told me about her breast augmentation. Later she said: 'Imagine how I felt, with you doing research on this subject and me having implants, I wanted to tell you but I couldn't. I did not want your family to find out because I didn't know what you would think of me...'. I offered Helen the information I had on silicone-gel implants, told her how to get in touch with the Christchurch implant support group, supplied her with the name and address of the Wellington Lawyer, and advised her to register a claim against the American manufacturers. After Helen told me she was to have her implants removed I gave her the name of the surgical corsetiere, advised her to talk to the corsetiere before her operation so she could have an idea about the range of the breast replacement options available to her. (June, 1993).

This incident was one of those special occasions where your research has an immediate practical value. Helen eventually made contact with the implant support group and I went with Helen to her first meeting. At the meeting I told the women about my research, they talked to me about their group and gave me large amounts of photocopied information. Helen and the women shared their stories and I asked if they would mind if I took notes because I thought it was important that some of their stories be documented. I returned the transcript the following week along with copies of additional articles about silicone-gel implants from my collection. I asked the women if they minded if I used some of the information from the transcript in the thesis and they agreed to this as long as fictitious names were used and dates altered to prevent accidental identification of individual women.

The impression I took away from that meeting, and one that stays with me now as I write this, is the way the women talked about the "absolute silence" surrounding breast implants. One woman had remarried and her new partner did not know about her breast implants, another had implants while her husband was overseas and she had not told him. Helen had not told her family about her implants until the results of her biopsy; another woman at the meeting was also in the same situation. All of the women said they felt uncomfortable talking about their implants outside the support group.

The silence surrounding breast implants meant that it was incredibly difficult to find women who were prepared to talk about their experience of breast augmentation. All six of the women whom I approached through a contact in Christchurch within the modelling profession refused to be interviewed. Again I was forced to fall back on my family network. I wrote to my cousin (a plastic surgeon's nurse) in Auckland. I sent her a copy of Chapter Three, together with copies of interview questions and asked her if it was at all possible for me to interview the surgeon for whom she worked and some women who were pleased with their breast augmentations. She rang me within a week: 'Yes it was possible to interview the surgeon, and how many women would you like to interview?' 'Just see what you can do', I replied. D... rang back the next day, she had told another plastic surgeon about me and he wanted to be interviewed. She had also contacted four women and arranged for me to ring them when I arrived in Auckland the following week. In Auckland I spent Thursday and Friday interviewing both of the surgeons and two of the women. In the end I decided not to interview the remaining two women because I felt Sarah and Isabel had already provided me with a wealth of information about breast augmentation (my timing turned out to be rotten because it was a long weekend and I felt awkward about intruding on their holidays).

## INTERVIEWING PEOPLE

I wanted to use in-depth face-to-face interviews. Talking about what you think about breast surgery, and how you experience your breasts, is not a familiar topic of conversation. So I had to establish an atmosphere in which people felt comfortable about talking about these topics, and in which they felt that I understood their experiences and concerns. I used open-ended questions. I asked all of the former cosmetic surgery clients the following question: 'What would you say to someone who thought cosmetic surgery was a form of

oppression and that women who engaged in it were narcissistic and vain?' I wanted the women I interviewed to speak for themselves about their experiences of doing breast work. I was looking for information that added a personal dimension to ideas about cosmetic surgery. I expected that the interviews would provide material that both challenged and reinforced dominant assumptions about cosmetic surgery. All of the people who agreed to be interviewed appeared to be happy about their involvement in the thesis. There was a tendency for them to expect that I would look at things from their point of view regardless of whether they were surgeons, corsetieres or clients. Sarah for example, provided the following feedback on my thesis topic:

Sarah: You know, I'm so pleased that someone is doing research on cosmetic surgery, who is looking at it from our point of view. (21/04/94).

In Chapter One I referred to magazine articles on cosmetic surgery. Many of these articles included pictures of either 'abnormal' or 'ideal' breasts<sup>7</sup>. Of interest to me was the way in which private acts of elective breast surgery, and personal ideas about breast shape, became the subject of public scrutiny in texts about cosmetic surgery. The women I interviewed were not content to simply discuss their breasts, but in many instances felt compelled to show the results of their breast surgery experiences. This need to 'show' was evident among all the women I interviewed who had undergone surgical procedures to enhance or perfect their breasts. For women who had received mastectomies or reconstructions, and for women who felt their breasts had in some way been deformed following cosmetic surgery there was a similar interest in showing what their breasts looked like:

Pamela: Do you want to have a look at it?

S: Yes. It's funny but all the women seem to like to show.

Pamela: Oh do they?

S: Yes

Pamela: Well I haven't shown anybody else...See how scarred I am...

S: That should settle down, often it takes a long time, it (the reconstruction) looks quite realistic.

Pamela: Yes it does, you can't complain.

S: No, I'm really impressed.

Pamela: Yes, I'm quite happy (25/10/93).

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<sup>7</sup> See: 'when less is more' *More* 07/93; 'Bellybutton route to bigger breasts', *NZIFW* 24/05/93; 'Plastic Surgery: What Price Perfection', *Mode* Oct/Nov. 93; 'Scarless Surgery', *Cleo*, 10/93; 'Look Me In The Eye...', *The Times Magazine*, 07/05/94.



In particular, the women who had undergone breast augmentation or reconstruction procedures, while being thrilled with the results of their surgery, critically discussed the way they felt about the contours and appearance of their 'new' breasts, and sought opinions from me about the placement of the nipple and whether their breasts looked 'natural'. In one of my first interviews with a surgical corsetiere I was shown several prostheses and was sufficiently impressed to write the following field notes:

I am surprised at how sophisticated the prostheses look. They are skin-coloured (cream, pink-cream, and brown) liquid silicone filled and shaped like the impossibly perfect breast of a twenty year old woman with pert nipples. They feel exactly like 'real breasts', the only difference being that they are cold - apparently they warm up once they come in contact with the body (06/11/92).

This captures my rapid exposure to new fields of experience and new technologies through involvement in the work on this project<sup>8</sup>.

Breast reduction procedures involves sculpting the body and enable the surgeon to express his or her individuality through the techniques used to recontour the breast. While breast reduction is constructed within the professional and popular literature as being a standardised procedure, once I became familiar with a plastic surgeon's work, I found it was possible to tell from variations in the shape of the breast, the incisions and placement of the nipple which cosmetic surgeon had performed which breast reduction procedure.

When interviewing the plastic surgeons I often felt my own body shape or aesthetic appearance was being appraised by the surgeons while I was talking to them. The first plastic surgeon I interviewed frequently used the personal pronoun 'you', which meant I sometimes got the impression that he was referring to me when he was talking about breast size and body image (see in particular the extract on distorted body image in Chapter Four Section 4.4). During an interview with another plastic surgeon this comparison between my appearance and cosmetic surgery was made very explicit:

...if you were to look into my room and say I don't like my face, can you do a face-lift? I'd say no because you are too young, your skin quality is too good you don't have any signs of aging, you know it is not on... (Plastic Surgeon 3: 22/04/93).

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<sup>8</sup> My cousin (the plastic surgery registrar) asked me if I'd like to observe an operation. As I'm soon to have (non-elective) surgery myself, I declined this generous offer.

All of the plastic surgeons asked how I viewed cosmetic surgery. The following provides an example:

Plastic Surgeon 3: What is your orientation to cosmetic surgery? How do you see it?  
 S: Well putting it very simply, I think historically 'feminists' have tended to be unsupportive of women who choose cosmetic surgery, and I think generally the media tends to make fun of the women as well, so I want to problematise these issues through talking to people like yourself who are involved in cosmetic surgery (22/04/94).

I encountered only two problems during the interviews. One of the surgical corsetieres did not want to be taped, so I had to write down her answers. I had come to the interview with a tape-recorder and not brought paper to do this, so I had to write crammed notes on the back of my question sheets (now I take both paper and a tape-recorder to my interviews) and I don't assume anything! While I was interviewing Plastic Surgeon 2, the tape finished before the end of the interview. I did not notice that this had happened, but fortunately only the answers to two questions were missed.

## WRITING UP

When I began this thesis, I thought I was going to write it from the top down, that is, to take "Theory" (with a capital T) and apply it to the experiences of people involved in cosmetic surgery. Although at the time it felt as if I was constructing the thesis from the ground up, I was in fact using the experiences of women clients, surgeons and corsetieres to problematise particular aspects of available theories about embodiment. I kept coming back to the same basic questions: What am I trying to say? How do I say it? Where do I want to go from here? I wrote each chapter at least four times. The hardest parts were writing the first draft of each chapter, developing links between the theory I had encountered and the information I had accumulated and making connections which tied particular arguments together.

The thesis divided easily into five chapters: my thesis proposal 'evolved' into an extensively rewritten theory section, and it seemed logical that the 'clients', 'experts' and 'silicone-gel controversy' should become separate chapters. Aside from this there were several pieces of work that could fit into several places. The hardest part of the thesis was threading the theory through the interview material and extracts from the print media in a way that did not interfere with

the development of the chapter. It is easy to agree in principle to integration of theory and research, it is more difficult to achieve this in practice.

The scarcity of feminist and sociological research into cosmetic surgery meant I had to use a variety of texts about embodiment in my analysis of cosmetic surgery. Given my orientation to the thesis I expected that I would find most feminist texts on cosmetic surgery or medicalisation of the body problematic. Jana Sawicki's text was the only piece of writing with which I found myself in total agreement. Feminist writing about embodiment and medicalisation tended either to construct oppositions between models of 'discourse analysis' and 'oppression', or to present doctors unproblematically as a homogeneous group or to cast women as the 'victims' of medical technologies and/or cultural dupes. This at times has had an impact on the way I have written the thesis. I have had to resist a tendency to generalise to all feminist theories of embodiment the analyses available about cosmetic surgery. I have also had to inhibit a tendency to generalise about the total population of clients and plastic surgeons, rather than use the material from my interviews to raise questions and indicate alternative ways of theorising about the social practices involved in cosmetic surgery. Hence my abstract tends to read like an apology about what the thesis cannot address. It does, however, remind me of the need to highlight the limits of the research endeavour on which this thesis is based.

## INTERVIEW QUESTIONS FOR THE PLASTIC SURGEON

How did you become interested in plastic surgery?

What sort of training did you receive?

Where?

When?

Have you always worked in New Zealand?

How are new techniques which are developed overseas learnt by established plastic surgeons here in New Zealand?

Are you involved in training plastic surgeons and/or passing on knowledge?

Do plastic surgeons make a distinction between plastic, cosmetic and aesthetic surgery? Are these appropriate labels?

What procedures do you perform most often?

Does this reflect the majority of people presenting at your clinic, or are some people referred elsewhere?

Do plastic surgeons refer patients between each other?

Are women of different ages presenting for different procedures?

Are Maori, Pacific Island and Asian women presenting at your clinic?

If so, are they presenting for the same cosmetic surgery procedures as European women?

What is the ratio of men to women presenting at your clinic?

Is the number of males increasing?

What are men presenting for?

In the last two years, has demand for certain surgical procedures changed?

What produced these changes? (For example: client demand, your own personal experiences, improved technologies/techniques etc.).

What percentage of women presenting to you for breast surgery are wanting to have breast reconstruction/cosmetic augmentation/breast reduction?

Are these appropriate labels?

What sort of information is available to women who might be deciding to have a breast reconstruction/augmentation/reduction? (How do they get information about these options?)

What are the options for reconstruction/reduction? (Fat transfer/muscle transfer, implants, natural breast enlargement)

Is 'scarless surgery' for breast enlargements currently available in New Zealand?

Do you think this procedure is safe?

In the case of breast reduction/augmentation, how is appropriate breast size determined?

Do you find you have to adapt your assessments of 'appropriate breast size' depending on whether large or small breasts are in fashion? (i.e. Are these changes client driven?).

I have read that liposuction is used by some medical practitioners. What is your opinion on this procedure?

How do you assess whether a plastic/cosmetic surgery procedure is going to be beneficial to a patient? (Are there certain categories of people to whom you would not recommend cosmetic surgery?)

I have read that in Australia, silicone implants have been withdrawn from the general market, although they are still approved for breast reconstruction following breast cancer surgery. I have also read that silicone-gel implants are discouraged by the Health Department in New Zealand but not banned.

Under what circumstances are silicone-gel implants currently available in New Zealand?

How do you negotiate the signing and maintenance of the silicone-gel implant register with your clients?

## INTERVIEW QUESTIONS FOR THE WOMEN FROM THE MASTECTOMY SUPPORT GROUP

First of all can you tell me how you came to be involved in this support group?

Can you tell me about your own experiences with breast cancer?

How long ago did you have your mastectomy?

Can you tell me a bit about the different types or degrees of mastectomy (i.e. full/partial)?

In your experience, is it easy for people to talk about mastectomy, or do people avoid talking about it?

Were there times when you wanted to talk and couldn't? (Why was that?)

Did you at any time consider breast reconstruction? (When?)

Who did you talk to? (discussion with family, friends)

Where did you get this information?

What decision did you come to?

What was the reason for your decision?

In general what percentages of women opt for prosthesis/reconstruction?

(Are there women who go through the support group and decide not to have either reconstruction or prosthesis?)

What factors encourage/discourage women from either of these options?

Is the cost of reconstruction a factor in discouraging some women from this option?

If women do not have augmentation or use a prosthesis does this affect their lifestyle?

What are some of the concerns women express to you when faced with the prospect of them having cancer/mastectomy?

Are these concerns respected and understood by medical professionals, family members etc.

Has the recent controversy surrounding silicone-gel breast implants, influenced/concerned/interested the women you have talked to?

Does the experience of mastectomy lead to a questioning of conventions about female body shape?

### *-Personal Information*

Can you give me a few personal details? (Name, age, occupation etc. if not already stated in the interview).

## INTERVIEW QUESTIONS FOR THE SURGICAL CORSETIERE

Can you tell me how you became involved in your occupation as a surgical corsetiere?

Can you tell me about the different services you provide?

What sorts of women come to you looking for help?

How do they find out about you?

At the point that they come to you are the women certain they want a prosthesis or do you have to sell the concept to them?

What sort of advice do you give to the women?

What sort of look are you trying to create?

Does the prosthesis interfere with a women's lifestyle?

Has there been an increase in your business because more women are reluctant to have implants and surgical reconstructions?

I understand you work in closely with the surgeons - can you tell me about that? (card, personal recommendation - how does the network work?)

What is the range of prostheses?

How do you and or the women decide what is the most suitable prosthesis for a given person?

How long does a prosthesis last?

Do women who have double mastectomies choose a different prosthesis size to their original breast size?

Are there different types, brands of prosthesis?

What is your relationship with the manufacturers?

What is the relationship between surgical corsetry and prosthesis corsetry?

Do the manufacturers who produce the prostheses also produce corsetry?

In bra size do you have a 32f?

What stage after surgery are women presenting to you?

What sort of training in addition to technical training have you acquired to cope with women who are quite traumatised through having a mastectomy?

Are women referred to you from the Cancer Society? } relationship

Do you refer women to the Cancer Society } between?

- *Personal information*

## APPENDIX TWO

### PRINT MEDIA TEXTS ON COSMETIC SURGERY

#### SILICONE-GEL BREAST IMPLANTS - listed by date

##### 1991-1992

- 'Silicone implants: Booming Busts'. Under the 'Science and Technology' section (*The Economist*, 12/01/91, p 81).
- 'Time Bombs in the Breast?' By Andrew Purvis under 'Medicine' (*Time*, 29/04/91, p. 45).
- 'Julie Breen's silent hell': ...The former fashion model unwittingly had a 'time-bomb' implanted in her chest - a bomb that has now exploded!... By Tony Barnao (*New Idea*, 04/05/91, pp. 32-33).
- 'Breast implants carcinogenic?' (Source: New York Times - *NZ Doctor*, 17/06/91).
- 'Women sue over breast implants' (Original source: Texas) Under 'Home and People' in *The Press*, 17/09/91.
- 'Toxic Breasts'. By Nicholas Reguish (*Mother Jones*, January/February 1992, pp. 24-31).
- 'Local surgeons are certain of breast implant safety'. By Lynne Laracy (*NZ Doctor*, 23/01/92).
- 'NZ Women prepare to sue over silicone' (*New Zealand Doctor*, 16/04/92).
- 'breast implant ruling due this week'. *The Dominion*, 30/04/92.
- 'Call to show fact sheet on gel implants' (Wellington P.A. - *Gisborne Herald*, 09/07/92).
- 'Keeping abreast of the dangers'. By Sandra Coney (*Dominion Sunday Times*, 12/07/92).
- 'Implant ban lifted'. By Michele Simpson. *North Shore Advertiser*, 14/07/92.
- 'Compensation sought for breast implants' (Waikato P.A. - *Evening Post*, 15/07/92).
- 'Woman seeks damages'. By Shelley Vercoe (*Nelson Evening Mail*, 15/07/92).
- 'Complaints on implants'. (Source: Hamilton P.A. - *The Press*, 16/07/92).
- 'Silicone Implants - A Case To Answer?' By Rosemary Vincent (*New Zealand Women's Weekly*, 20/07/92, pp. 28-30).
- 'Implants worry Nelson woman'. By Shelly Vercoe (*Nelson Evening Mail*, 23/07/92).
- 'Implant woman fears for health' (Auckland P.A. - *North Shore Advertiser*, 28/07/92).
- 'US doctors failed patients over silicone implants'. By Brett Reid (*NZ General Practice*, 05/08/92).
- 'Reassurance for women with implant fears' (*GP Weekly News*, 02/09/92).
- 'Women with silicone gel breast implants to go on register', under Te Tari Ora (regular column from the Department of Health) in *NZ General Practice*, 02/09/92.
- 'Surgeons give free advice on implants' (*NZ Doctor*, 03/09/92).
- 'Implant consultations' (*The Dominion*, 07/09/92).
- 'Silicone triggers specific immune reactions - study' (Original source London - *GP Weekly International*, 09/09/92).
- 'Women with silicone gel breast implants to go on register', under Te Tari Ora (regular column from the Department of Health) in *GP Weekly International*, 09/09/92.
- 'Implant research vital 'first step' (*Gisborne Herald*, 16/09/92).
- 'Implant scrutiny proposed' (*Waikato Times*, 16/09/92).
- 'Lawyer wants implants banned' (Wellington PA - *Oamaru Mail* 16/09/92).
- 'Lawyer wants review of policy on silicone implants' (Wellington PA - *Otago Daily Times*, 16/09/92).
- 'Research casts doubt on implants' (*The Dominion*, 16/09/92).
- 'Shadow cast over implants' (Wellington PA - *Timaru Herald*, 16/09/92).
- 'Shadow over implants' (Wellington NZPA - *Marlborough Express*, 16/09/92).
- 'Shadow over implants' (*Evening Post*, 16/09/92).
- 'Silicone concerns reinforced' (Wellington PA - *The Press*, 16/09/92).
- 'Silicone Implant policy should be reviewed' (*Southland Times*, 16/09/92).
- 'Silicone Review call' (Wellington P.A. - *Bay of Plenty Times*, 16/09/92).



- 'Silicone risks shown - lawyer' (Wellington NZPA - *Northern Advocate*, 16/09/92).
- 'Study prompts call for implant review' (Wellington P.A. - *Nelson Evening Mail*, 16/09/92).
- 'Meeting called over prosthetics' (*Hawke's Bay Herald Tribune*, Hastings, 17/09/92).
- 'Silicone link seen to immune responses' (London) *Daily Telegraph*, Napier 23/09/92).
- 'Silicone Nightmare': Breast implants were to end years of problems for Joy Bradey, but instead they nearly destroyed her life and still pose a threat to her health (*Woman's Day*, 17/11/92, pp. 12-13).
- 'He doesn't know my breasts are fake', ...She turned to implants to win back her neglectful husband's affection. Now she's afraid to tell the new man in her life and terrified she'll end up with cancer.. (*Woman's Day*, 24/11/92, p. 36).
- 'Breast Implants - the facts - not media hype' (*Glaze*, Summer 92/93, p. 47).
- 'Breast Implants Furore and Facts' (*Glaze*, Summer 92/93, pp. 31-32).

## 1993

- 'Silicone Breast Implant Removal' (*Siren*, February 1993).
- 'Breast implants linked to new diseases'. (Wellington P.A. - *The Press*, 11/02/93).
- 'Women 'afraid' to seek implant data'. (Christchurch P.A. - *The Press*, 22/04/93).
- 'Payout looms on breast implants'. By Kim Newth (*The Christchurch Mail*, 10/06/93).
- 'Jessica's Implant Horror', by Kathleen Tracy in *New Idea*, 19/06/93.
- 'Silicone Baby': ...A tormented mum fears she may have poisoned her young son... By Kerrie Theobald (*Woman's Day*, 17/08/93, p.21).

## 1994

- 'Implant scare limits treatment' (*NZ Doctor*, 03/02/94).
- 'Silicone scare leads to hunt for options' (*NZ Doctor*, 03/02/94).
- 'breast implants: the pros and cons', by Dr Gregory D. Taylor. *HealthCare*, March, 1994 (Amcal Chemists Magazine) pp. 30-32.
- 'The Enemy Inside' (*More*, March, 1994, pp. 34-41).
- 'Silicone Valleys': (The young Kiwi mums hoped breast augmentation surgery would help them regain their figures - instead, they ended up feeling 'really deflated' and worse). By Jacki Rorani (*New Idea*, 02/03/94).
- 'Look me in the eyes and tell me they're safe': ...At least 30,000 women in America have had breast implants removed since the use of silicone was banned there and 25,000 are suing the manufacturers. Yet in Britain, thousands of women are still having the operation which might cripple them for life... By Kate Muir (*The Times Magazine*, 07/05/94).
- 'Hurry to claim over implants' (*The Christchurch Mail*, 16/06/94).
- 'Evidence casts doubt on implant-illness link'. (*The Press*, 17/06/94).
- 'Rod Stewart's ex-wife Alana has become the first Hollywood celebrity to sue over breast implants...' under 'Headliners' (*New Zealand Woman's Weekly*, 27/06/94).
- 'Alana's implant shock', ...Rod Stewart's former wife Alana Hamilton blames silicone breast implants for her years of suffering...The modest curves seemed like harmless, morale-boosting fun back then, but in retrospect they appear more like ticking time bombs. By Sue Russell, in *New Idea*, 26/07/94.

## 'WOMEN'S MAGAZINES'

### 1991-1992

- Plastic Surgery No Way! (*N.Z.W.W.*, 10/06/91, pp. 6-8).
- 'Breast-Enlargement Warning' (on Natural breast enlargement), under 'Bodytalk' by Karen Nimmo in *More*, 05/92.
- Plastic Surgery: what if you could try before you buy? (*Cleo*, July, 1992).

'Fat Chance' (on Liposuction), *Elle*, September, 1992.

'Cross-cultural Body Image'. ...Cosmetic Surgery: Australians have one of the highest percentages of women going in for cosmetic surgery. In Argentina only upper class women went in for cosmetic surgery. Women in Veit-nam also went in for cosmetic surgery to make their eyes and noses look 'more Western'... By Indrani Ganguly in *Broadsheet*, Spring, 1992, pp. 22-23.

'Plastic Surgeons Who Practise On Their Wives'. By Sharon Church, under 'A Stitch in Time', in *The Australian Women's Weekly*, November, 1992, pp. 41-44.

#### 1993-1994

What Cosmetic Surgery Can Do For You (*The Australian Women's Weekly*, February, 1993, pp. 105-111).

'Bellybutton route to bigger breasts'. (Hollywood's Dr Ian Brown is one of a handful of cosmetic surgeons who enlarge breasts with salt water implants, by tunnelling from the navel. He claims the procedure takes only 20 minutes, leaves no visible scars - and that patients are fit enough to go shopping the next day). By Frank Durham in *New Zealand Women's Weekly*, 24/05/93, pp. 78-79.

'Cutting edge. Should you? Or shouldn't you?' ...More and more Londoners, yearning to the knifestyles of the rich and famous, are undergoing sophisticated cosmetic surgery... By Sarah Stacey in *ES* June, 1993.

'when less is more' (down-sizing when breast surgery changes lives), *More* July, 1993, pp. 48-55.

'The Plane Truth: Saville Jackson follows up her face-lift with skin-resurfacing surgery' (*Vogue*, August, 1993, pp. 158-159).

'My Breasts Felt Like Aliens'. ...An article in the NZ Woman's Weekly [24/05/93] on a new type of breast enlargement surgery used in the United States sparked a huge response from readers... (*New Zealand Woman's Weekly*, 02/08/93, pp. 40-43).

'4000 Years Of Plastic Surgery', under 'Health' in *Fashion Quarterly New Zealand*, Summer 1993 pp. 74-75.

'Liposuction: An Empty Promise?' (*Fashion Quarterly New Zealand*, Summer 1993, pp. 184-187).

'Scarless Surgery.' ...breast implants inserted through your navel,...all through a new revolutionary form of surgery without scars. (*Cleo*, October, 1993).

'Plastic Surgery: What Price Perfection' (*Mode* October/November, 1993, pp. 128-133).

"I had plastic surgery to look like a Barbie Doll". By Diane Poitras in *Cleo*, December, 1993, pp. 78-79.

'Nothing But the Tooth!' Behind the gleaming smiles of many showbiz's biggest names lurks a dark secret...they have turned to cosmetic dentistry to acquire the sort of straight pearly-white teeth nature failed to give them'. (*NZWW*, 25/04/94, pp. 46-47).

'what will it cost to make me beautiful' (*Cosmopolitan*, July, 1994, pp. 114-117).

## COSMETIC SURGERY ON CELEBRITIES

#### 1991-1992

Lips, Exploding Breast! Plastic surgery is by no means a sure-fire route to perfect looks, as a number of stars have found to their cost'....Kate O'Mara....breast exploded on impact (*N.Z.W.W.*, 25/04/91).

'Shrinking Roseanne': ...A combination of plastic surgery and diet is helping Roseanne Arnold performs an impressive disappearing act... (*N.Z.W.W.*, 21/09/92).

'No Knife for Jenny': ...[Actress] Jenny Agutter has revealed that she was once told she needed plastic surgery, but decided to live with her imperfections... (*N.Z.W.W.*, 30/11/92, p. 16).

'Hollywood Goes Under the Knife': ...Meryl Streep and Goldie Hawn star in a new movie [Death Becomes Her] that takes a shot at Hollywood's obsession with eternal youth - the whole face-lifting, tummy-tucking, bottom-tightening, fat-sucking, hair-plugging, cheek puffing bit!...Hollywood is not merely biting the hand wielding the scalpel that keeps its magnified celluloid faces forever youthfully plastic. It's chewing off the entire limb... (N.Z.W.W., 28/12/92, pp. 36-37).

### 1993

'Dolly's Facelift Slips': ...The country superstar is devastated after costly plastic surgery leaves her chin and neck in a mess... By David Wigg in *Woman's Day* 27/04/93 pp. 42-43).

'Demi's Fake Breasts Amazing Expose' (Front cover) 'Shock! Demi's Fake Boobs': ...There's Moore to sexy Demi than meets the eye... By Kathleen Tracy in *Woman's Day*, 18/05/93, pp. 6-7.

'Roseanne's Facelift': ...John-Micheal Howson reveals how the fiery star's obsession with her husband Tom led her to surgery... (*Woman's Day*, 06/07/93).

'Now I Want To Pose For Playboy'. ...It has taken diet, exercise, a nose job, breast reduction, a tummy tuck, and liposuction on bottom and thighs. But now Roseanne Arnold...Believes she's the fairest of them all.... By Drew MacKenzie in *New Zealand Woman's Weekly*, 07/06/93 pp. 20-21.

'Securing Her Assets': ...Slimmer hips, younger eyes, cheekier grin, waspier waist - Dolly Parton has just endured a marathon operation to streamline herself for her fans... (N.Z.W.W. 08/03/93).

'Tina Turner -Hot affairs and secret surgery' (Front cover). 'Exclusive: Tina's Raunchy Past' ...Tina was excited about her new boobs...She had the bridge of her nose raised slightly, and later had the varicose veins removed from her wonderful legs... (*Woman's Day*, 10/08/93, pp. 18-20).

'Busted! Who has and hasn't had a boob job in Hollywood'. By Samantha Jones in *Cleo*, September, 1993, pp. 116-119.

'I Hated My Body': ...Doting wife Jane Fonda has come clean about her plastic surgery, her obsession with exercise and the eating disorder that plagued her life for 22 years... By Tony Brenna in *N.Z.W.W.*, 18/10/93,

### 1994

'Nip and Tuck Stars': ...The changing faces of Hollywood have been honoured in the Nip and Tuck awards. Competition was fierce, but a panel of experts placed singer Tina Turner, supermodel Cindy Crawford and actress Goldie Hawn among stars at the cutting edge of plastic surgery... (*Woman's Day* 22/02/94).

'Star Boo Boos'. By Dr Rosie King in *Woman's Day*, 22/03/94,

'Facelifts without surgery': ...The nip and tuck is out as Hollywood's showbiz set rush to sample an exciting and painless new anti-ageing technique... (*Woman's Day* 10/05/94).

'Hollywood's secret army': ...Boosting Breasts, Egos and Images. 'Behind every glamour image is an army of men and women - everyone from hairdressers, trainers and nutritionists to plastic surgeons, psychiatrists and divorce attorneys - who are so essential they become stars in their own right... By Ivor Davis, in *N.Z.W.W.*, 30/05/94.

'Magic Knife': ...Today, some of the biggest names in showbiz would look less attractive were it not for the skills of their plastic surgeon...Among the famous faces who have gone under the knife for various enhancements are Cher, Bo Derek, Elizabeth Taylor, Roseanne Arnold, Michael Douglas, Jane Fonda, Raquel Welch, Phyllis Diller, Loni Anderson, Burt Reynolds, and, of course, Michael, Janet and La Toya Jackson... (N.Z.W.W., 20/06/94).

'Pamela's Breast Agony': The Baywatch beauty thought the only way to make it big was to make herself bigger...I was so disappointed. I thought I was going to have tremendous breasts but in fact I am the same bra size now as I was before. The shape has just changed and they are a bit fuller... (*Woman's Day*, 02/08/94).

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'Vanity Fare: Cosmetic Surgery When it turns ugly...' by Pamela Stirling in *Listener & TV Times*, 28/08/91, pp. 16-23.

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## NEWSPAPER ARTICLES, ADVERTISEMENTS AND 'EDITORIAL/ADVERTS'

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'Classic artists create timeless beauty. Plastic Surgery Arts' (Advertisement: *Cleo*, August, 1985).

'Farewell Fat with Liposuction: You can look good again!' (Advertisement: *The Press*, 10/02/90).

'The Suction Solution' (editorial/advert on liposuction). By Deborah McPherson in *The Press*, 16/04/91.

'Breast reduction, 'worth more than the money" (editorial/advert on breast reduction) in *The Press*, 04/06/91.

'Correcting nature's design flaws': ...Glenys Bowman looks at the options for women who are not happy with the size or shape of their breasts.... Press Fashion, June. (editorial/advert in *The Press*, 04/06/91).

'Liposuction brings enhancement of life' (editorial/advert, *The Christchurch Star* 25/06/91).

### 1992

'I am living proof of the third sex': (Christie Elan-Cain has transformed her body surgically to become an 'androgynous' - neither female or male). By Andrea Stuart in *The Press*, 20/06/92.

'Facing up to the Body'. By Stephen Quinn in 'Watching Brief'. *The Whanganui Report*, 03/07/92.

"Cosmetic surgery has given me so much confidence and changed my whole world" (editorial/advert on liposuction in *The Christchurch Star*, 04/07/92).

'Process firm in favour' (editorial/advert on collagen injection) *NZ Herald*, under 'Health', 11/08/92).

Unskilled cosmetic surgeons' unsightly legacy' (*Marlborough Express*, 06/10/92).

### 1993

'Miracle Breasts For Cancer Victims': ...A clever new technique uses tummy tissue to create natural breasts.... By Liz Johnswood in *Woman's Day*, 31/08/93.

'Mirror, Mirror: Imagined ugliness is driving some women to suicide'. (*N.Z.W.W.*, 04/10/93).

'Reduce to boost lifestyle' (editorial/advert on breast reduction) *The Christchurch Star*. Fashion Supplement, November, 1993.

'Surgeons say sculptor boobed'. ...Plastic surgeons say Michelangelo messed up badly when it came to women's breasts... (Original source: Australian Doctor Weekly - *The Press*, 12/12/93).

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'Surgery on stubborn areas' (advert/editorial on liposuction) *Christchurch Star*, 16/02/94.

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'Implants given to anorexic women' (*The Press*, 04/05/94).

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'Gender reassignment in New Zealand' (*Siren*, October, 1992)

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"I had a sex change to become a man". By Paula Hunter in *Cleo*, September, 1993, pp. 120-122.

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'Secret Face-Lift!' ...Now at last...the truth about Cliff Richard's youthful looks... (*N.Z.W.W.*, 18/04/94)

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- 'Findings against surgeon' (Wellington P.A. - *The Daily Post*, 09/07/92).
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- 'Surgeon ordered to stop' (*Bay of Plenty Times*, 10/07/92).
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